SERFF Tracking Number:	*SEFL-126544635*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*45354*
Company Tracking Number:	*PDI H0920*		
TOI:	*H11I Individual Health - Disability Income*	*Sub-TOI:*	*H11I.008 Combined Short Term and Long Term - Unrelated to marketing with employer or association groups*
Product Name:	*PDI H0920*		
Project Name/Number:	*PDI H0920/PDI H0920*		

Filing at a Glance

Company: Assurity Life Insurance Company

Product Name: PDI H0920	SERFF Tr Num: SEFL-126544635	State: Arkansas
TOI: H11I Individual Health - Disability Income	SERFF Status: Closed-Approved-Closed	State Tr Num: 45354
Sub-TOI: H11I.008 Combined Short Term and Long Term - Unrelated to marketing with employer or association groups	Co Tr Num: PDI H0920	State Status: Approved-Closed
Filing Type: Form/Rate		Reviewer(s): Rosalind Minor
	Author: Kristi Hendrickson	Disposition Date: 04/30/2010
	Date Submitted: 04/05/2010	Disposition Status: Approved-Closed
Implementation Date Requested:		Implementation Date:

State Filing Description:

General Information

Project Name: PDI H0920
Project Number: PDI H0920
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 04/30/2010

Deemer Date:
Submitted By: Kristi Hendrickson
Filing Description:

Status of Filing in Domicile: Authorized
Date Approved in Domicile: 03/26/2010
Domicile Status Comments: Approved
Market Type: Individual
Group Market Size:
Group Market Type:
Explanation for Other Group Market Type:
State Status Changed: 04/30/2010
Created By: Kristi Hendrickson
Corresponding Filing Tracking Number:

Form Numbers	Form Title
I H0920 (AR)	Disability Income Policy
OC-I H0920 (AR)	Outline of Coverage
R I0921	Own Occupation Rider
R I0922	Automatic Benefit Increase Rider

SERFF Tracking Number:	*SEFL-126544635*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*45354*
Company Tracking Number:	*PDI H0920*		
TOI:	*H11I Individual Health - Disability Income*	*Sub-TOI:*	*H11I.008 Combined Short Term and Long Term - Unrelated to marketing with employer or association groups*
Product Name:	*PDI H0920*		
Project Name/Number:	*PDI H0920/PDI H0920*		

R I0923 Catastrophic Disability Benefit Rider
R I0924 Guaranteed Insurability Rider
R I0925 Non-Cancelable Rider
R I0926 Residual Disability Benefit Rider
R I0927 Retroactive Injury Benefit Rider
R I0928 Return of Premium Benefit Rider
R I0929 Supplemental Disability Income Rider
47-360-05051 (R03-10) Disability Income Product Section of application

Assurity Life Insurance Company submits the above captioned forms and associated rates for review and approval. We are also asking approval of a multi-life premium discount.

The above forms have not been previously submitted. Upon approval, they will replace forms as indicated below:

Form No. Form Replaced Approval Date
I H0920 (AR) A-D 100 02/03/1997
OC-I H0920 (AR) A-OC-D 100 (R01-08) 02/12/2008
R I0921 A-DR 204 02/03/1997
R I0922 A-DR 205 02/03/1997
R I0923 A-DR 218 04/16/2001
R I0924 R D221 03/02/2005
R I0925 A-DR 203 02/03/1997
R I0926 R D220 03/02/2005
R I0927 R D222 03/02/2005
R I0928 A-DR 208 09/30/1998
R I0929 A-DR 200 (9/95) 02/03/1997
47-360-05051 (R03-10) 47-360-05051 (R01-08) 02/12/2008

Form I H0920 (AR) is a disability income policy that provides a monthly benefit if the insured is totally disabled.

Form OC-I H0920 (AR) is the corresponding outline of coverage for policy form I H0920 (AR).

Form R I0921 is an optional rider extending the Own Occupation time frame in the Total Disability definition.

Form R I0922 is an optional rider providing for an annual increase equal to 5% of the original monthly benefit amount on each anniversary of the date of total disability if an insured person’s continuous disability exceeds 12 months.

Form R I0923 is an optional rider providing an additional monthly benefit once all benefits under the policy have been paid if the insured person is catastrophically disabled.

Form R I0924 is an optional rider providing options to purchase additional benefits without providing evidence of insurability.

Form R I0925 is an optional rider making the policy and any attached riders non-cancelable.

Form R I0926 is an optional rider providing benefits based on the insured person's inability to perform one or more of the substantial and material duties of an occupation and experiencing at least a 20% loss of income.

Form R I0927 is an optional rider providing disability benefits back to the first day of total disability if the insured person is continuously disabled as the result of an injury through the elimination period.

Form R I0928 is an optional rider that will provide for a return of a percentage of the premium paid for the base policy and most riders attached to the policy.

Form R I0929 is an optional rider that will pay an additional benefit amount if the insured person is not receiving any social insurance benefits or if the social insurance benefits they are receiving are lower than the benefit amount of this rider.

Form 47-360-05051 (R03-10) is the disability product page of the application that will be used for policy form I H0920.

Multi-Life Premium Discount features:

- 15% discount applies to all premiums, including riders (except the Return of Premium Rider), ratings and policy fee
- all occupation classes are eligible for the discount
- all applications will be fully underwritten
- groups are eligible if coverage is being provided to three or more lives in an employer group under a list bill
- insureds added to an existing group that is receiving the discount will also receive the discount
- discount will continue if the insured leaves the group

This discount will be sold to groups with established employer-employee relationships. It will not be marketed to Association Groups or Credit Unions.

SERFF Tracking Number:	*SEFL-126544635*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*45354*
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TOI:	*H11I Individual Health - Disability Income*	*Sub-TOI:*	*H11I.008 Combined Short Term and Long Term - Unrelated to marketing with employer or association groups*
Product Name:	*PDI H0920*		
Project Name/Number:	*PDI H0920/PDI H0920*		

Please note that previously approved form I R0721 (AR), Critical Illness Benefit Rider, will be available with this policy. Form I R0721(AR) was approved by your office on February 12, 2008.

Along with application page 47-360-05051 (R03-10), the following application pages will be used in applying for this product:

Form No. Title Approval Date
47-350-05051 (R02-08) Application for Insurance 04/10/2008
47-351-05051 Trust Information/Additional Beneficiary 12/07/2006
47-352-05051 (R02-08) General Section 04/10/2008
47-353-05051 (R02-08) Health Section 04/10/2008
47-354-05051 (R02-08) Primary Physician Information/Agreement 04/10/2008
47-362-05051 (R02-08) Field Underwriter's Statement 04/10/2008

A sample of the application forms packaged is attached under the Supporting Documentation tab.

Marketing: This product will be distributed by licensed agents and brokers.

Company and Contact

Filing Contact Information

Kristi Hendrickson, Policy Filing Specialist
1526 K Street
Lincoln, NE 68508

policyfiling@assurity.com
402-437-3452 [Phone]
402-437-3802 [FAX]

Filing Company Information

Assurity Life Insurance Company
1526 K Street
P.O. Box 82533
Lincoln, NE 68501-2533
(800) 276-7619 ext. [Phone]

CoCode: 71439
Group Code: -99
Group Name:
FEIN Number: 38-1843471

State of Domicile: Nebraska
Company Type: Life/Health
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00

SERFF Tracking Number:	*SEFL-126544635*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*45354*
Company Tracking Number:	*PDI H0920*		
TOI:	*H11I Individual Health - Disability Income*	*Sub-TOI:*	*H11I.008 Combined Short Term and Long Term - Unrelated to marketing with employer or association groups*
Product Name:	*PDI H0920*		
Project Name/Number:	*PDI H0920/PDI H0920*		
Retaliatory?	No		
Fee Explanation:	$50 per form and $50 per rate		
Per Company:	No		

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Assurity Life Insurance Company	$100.00	04/05/2010	35386889
Assurity Life Insurance Company	$500.00	04/06/2010	35424465

SERFF Tracking Number:	*SEFL-126544635*	*State:*	*Arkansas*
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Product Name:	*PDI H0920*		
Project Name/Number:	*PDI H0920/PDI H0920*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/30/2010	04/30/2010

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Additional filing fees	Note To Filer	Rosalind Minor	04/06/2010	04/06/2010

SERFF Tracking Number:	*SEFL-126544635*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*45354*
Company Tracking Number:	*PDI H0920*		
TOI:	*H11I Individual Health - Disability Income*	*Sub-TOI:*	*H11I.008 Combined Short Term and Long Term - Unrelated to marketing with employer or association groups*
Product Name:	*PDI H0920*		
Project Name/Number:	*PDI H0920/PDI H0920*		

Disposition

Disposition Date: 04/30/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*SEFL-126544635*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*45354*
Company Tracking Number:	*PDI H0920*		
TOI:	*H11I Individual Health - Disability Income*	*Sub-TOI:*	*H11I.008 Combined Short Term and Long Term - Unrelated to marketing with employer or association groups*
Product Name:	*PDI H0920*		
Project Name/Number:	*PDI H0920/PDI H0920*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Statement of Variabiltiy	Approved-Closed	Yes
Form	Disability Income Policy	Approved-Closed	Yes
Form	Outline of Coverage	Approved-Closed	Yes
Form	Own Occupation Rider	Approved-Closed	Yes
Form	Automatic Increase Benefit Rider	Approved-Closed	Yes
Form	Catastrophic Disability Benefit Rider	Approved-Closed	Yes
Form	Guaranteed Insurability Rider	Approved-Closed	Yes
Form	Non-Cancelable Rider	Approved-Closed	Yes
Form	Residual Disability Benefit Rider	Approved-Closed	Yes
Form	Retroactive Injury Benefit Rider	Approved-Closed	Yes
Form	Return of Premium Benefit Rider	Approved-Closed	Yes
Form	Supplemental Disability Income Rider	Approved-Closed	Yes
Form	Disability Income Product Section	Approved-Closed	Yes
Rate	Attachment A	Approved-Closed	No

SERFF Tracking Number:	*SEFL-126544635*	*State:*	*Arkansas*
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Product Name:	*PDI H0920*		
Project Name/Number:	*PDI H0920/PDI H0920*		

Note To Filer

Created By:
Rosalind Minor on 04/06/2010 10:34 AM
Last Edited By:
Rosalind Minor
Submitted On:
04/30/2010 09:19 AM
Subject:
Additional filing fees
Comments:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH.

The new fee for this submission is $50.00 per form for a total of $600.00. Please submit an additional $500.00 for this filing.

We will begin our review of this submission upon receipt of the additional fees.

SERFF Tracking Number:	*SEFL-126544635*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*45354*
Company Tracking Number:	*PDI H0920*		
TOI:	*H11I Individual Health - Disability Income*	*Sub-TOI:*	*H11I.008 Combined Short Term and Long Term - Unrelated to marketing with employer or association groups*
Product Name:	*PDI H0920*		
Project Name/Number:	*PDI H0920/PDI H0920*		

Form Schedule

Lead Form Number: I H0920 (AR)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 04/30/2010	I H0920 (AR)	Policy/Contract/Fraternal Certificate	Disability Income Policy	Initial		50.000	AR_I H0920_Policy.pdf
Approved-Closed 04/30/2010	OC-I H0920 (AR)	Outline of Coverage	Outline of Coverage	Initial		50.000	AR_OC-I-H0920_Outline.pdf
Approved-Closed 04/30/2010	R I0921	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Own Occupation Rider	Initial		50.300	R I0921_Own Occ.pdf
Approved-Closed 04/30/2010	R I0922	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Automatic Increase Benefit Rider	Initial		59.500	R I0922_Auto Benefit Increase.pdf
Approved-Closed 04/30/2010	R I0923	Policy/Contract/Fraternal Certificate:	Catastrophic Disability Benefit Rider	Initial		51.200	R I0923_Catastrophic Disability.pdf

		Amendment, Insert Page, Endorsement or Rider				
Approved-Closed 04/30/2010	R I0924	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Guaranteed Insurability Rider	Initial	53.500	R I0924_GIR.pdf
Approved-Closed 04/30/2010	R I0925	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Non-Cancelable Rider	Initial	51.300	R I0925_NonCancelable.pdf
Approved-Closed 04/30/2010	R I0926	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Residual Disability Benefit Rider	Initial	53.300	R I0926_Residual.pdf
Approved-Closed 04/30/2010	R I0927	Policy/Contract/Fraternal Certificate:	Retroactive Injury Benefit Rider	Initial	56.200	R I0927_Retroactive.pdf

SERFF Tracking Number:	*SEFL-126544635*		*State:*	*Arkansas*		
Filing Company:	*Assurity Life Insurance Company*		*State Tracking Number:*	*45354*		
Company Tracking Number:	*PDI H0920*					
TOI:	*H11I Individual Health - Disability Income*		*Sub-TOI:*	*H11I.008 Combined Short Term and Long Term - Unrelated to marketing with employer or association groups*		
Product Name:	*PDI H0920*					
Project Name/Number:	*PDI H0920/PDI H0920*					
		Amendment, Insert Page, Endorsement or Rider				
Approved-Closed 04/30/2010	R I0928	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Return of Premium Benefit Rider	Initial	50.600	R I0928_ROP.pdf
Approved-Closed 04/30/2010	R I0929	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Supplemental Disability Income Rider	Initial	51.900	R I0929_Supplemental DI.pdf
Approved-Closed 04/30/2010	47-360-05051 (R03-10)	Application/Enrollment Form	Disability Income Product Section	Initial	50.100	47-360-05051_R03-10_ 3-22.pdf

This is a legal contract between You (the insured person) and Us (Assurity Life Insurance Company, a stock company). It is issued in return for Your approved application and Initial Premium. We agree to pay this policy's benefits to You while this policy is in force and after this policy's provisions have been met.

The provisions of this policy apply to any riders attached to this policy unless otherwise stated in the riders.

RENEWAL

This policy is guaranteed renewable to age [65]. That means as long as You pay premiums when due, We cannot cancel or change this policy. We can, however, change the premium rates. If We change the premium rates, We can only do it after approval or acknowledgement by Your state for all insured persons in Your class. You will be given 31 days notice by mail prior to any premium change. If You are over age [65], You must be Employed on a Full-Time Basis to renew this policy on each policy anniversary to age 75. After age [65], the Maximum Benefit Period is limited to one year, and Your premium will change on each policy anniversary.

RIGHT TO CANCEL

You may cancel this policy within 30 days of receiving it by returning this policy to Our administrative office. As soon as You deliver or mail this policy to Us, it is treated as if it was never issued. Your premium payment will be refunded when We receive this policy. After the 30-day period, You may cancel this policy by notifying Us in writing that You wish to do so. This policy will be cancelled on the date We receive Your written notice unless Your notice specifies a later date. Cancellation of this policy will be without prejudice to any claim made prior to the termination of this policy.

Assurity Life Insurance Company has signed this policy on the Issue Date.

President

Secretary

Assurity Life Insurance Company
Administrative Office
PO Box 82533, Lincoln, Nebraska 68501-2533
Toll-free (800) 869-0355

DISABILITY INCOME POLICY

Guaranteed Renewable to Age [65] ● Qualified Right to Renew to Age 75
Company may change premium rates

Representative Name: [ ]
Address: [ ]
[ ]
[ ]
[ ]
Telephone: [ ]

TABLE OF CONTENTS

POLICY SCHEDULE

FORM NO.	FORM NAME	BENEFIT	INITIAL ANNUAL PREMIUM
I H0920 (AR)	Disability Income Policy		$[ ]
	Total Disability Monthly Benefit	[ ]	
	Maximum Benefit Period	[ ]	
	Elimination Period	[ ] consecutive days	
	Partial Disability Monthly Benefit	[ ]	
	Maximum Partial Benefit Period	6 Months	
[R I0921	[5-Year] Own Occupation Rider		$[ ]
R I0922	Automatic Benefit Increase Rider		$[ ]
R I0923	Catastrophic Disability Benefit Rider		$[ ]
	Catastrophic Disability Monthly Benefit	[ ]	
	Maximum Catastrophic Benefit Period	[ ]	
R I0924	Guaranteed Insurability Rider		$[ ]
	Maximum Increase Amount	[ ]	
R I0925	Non-Cancelable Rider		$[ ]
R I0926	Residual Disability Benefit Rider		$[ ]
	Maximum Residual Benefit Period	[ ]	
	Elimination Period	[ ] consecutive days	
R I0927	Retroactive Injury Benefit Rider		$[ ]
R I0928	Return of Premium Benefit Rider		$[ ]
R I0929	Supplemental Disability Income Rider		$[ ]
	Supplemental Disability Income Monthly Benefit	[ ]	
	Maximum Supplemental Benefit Period	[ ]	
I R0721	Critical Illness Benefit Rider		$[ ]
	Benefit Amount	[ ]	
	Multi Life Discount		-$[ ]]

Insured Person: [ ]
Age: [ ]
Gender: [ ]
Class: [ ]

Policy Number: [ ]
Issue Date: [ ]
Initial Premium: $[ ]
Premium Period: [ ]

Premium Modes:

Annual:	$[ ]	Quarterly:	$[ ]
Semi-Annual:	$[ ]	Monthly:	$[ ]

DEFINITIONS

Any Gainful Occupation means an occupation, which fits You by education, training or experience and replaces or is expected to replace 60% or more of Your Prior Monthly Income.

Complication of Pregnancy means a condition when the pregnancy is not terminated, with diagnosis which is distinct from pregnancy, adversely affected by pregnancy or caused by pregnancy, and includes, but which is not limited to: acute nephritis, anemia of pregnancy, nephrosis, cardiac decompensation, incompetent cervix, missed abortion, placenta previa, puerperal infection and similar medical and surgical conditions of comparable severity. It also includes emergency Caesarean section delivery, ectopic pregnancy which is surgically terminated, spontaneous termination of pregnancy which occurs during a period of gestation when a viable birth is not possible, hyperemesis gravidarum (pernicious vomiting), pre-eclampsia and eclampsia. Complications of Pregnancy cease upon termination of the pregnancy.

Complication of Pregnancy does not include false labor, pre-term contractions of labor, advanced maternal age, occasional spotting, non-emergency Caesarean section delivery, postpartum depression, Physician prescribed rest during the period of pregnancy, morning sickness and similar conditions which, although associated with the management of a difficult pregnancy and back pain, are not medically classified as a distinct Complication of Pregnancy.

Concurrent Disabilities means disabilities caused by more than one Injury or Sickness, whether they are related or not.

Covered Accident means an unforeseen event or occurrence which directly, independently and exclusively results in an Injury and (a) occurs after this policy's Issue Date; (b) occurs while this policy is in force; and (c) is not caused by or a result of an activity or condition listed in the Exclusions section of this policy.

Elimination Period means the number of consecutive days You must be Totally Disabled before You are eligible to receive the benefits as shown on the Policy Schedule. We do not pay benefits during the Elimination Period.

Employed on a Full-Time Basis means working for pay at least 30 hours per week.

Immediate Family means Your spouse, father, mother, children or siblings.

Injury means bodily harm that is caused solely by or is the result of a Covered Accident. All Injuries sustained in any one Covered Accident and all complications and reoccurrences of complications are considered to be a single Injury.

Issue Date means the date this policy was issued as shown on the Policy Schedule.

Maximum Benefit Period means the maximum period of time any combination of Total Disability Monthly Benefits and Partial Disability Monthly Benefits, if any, are paid as shown on the Policy Schedule.

Benefits will not be paid past Your age [65] except:

- if the Total Disability starts after You are [63], the Maximum Benefit Period is two years; or
- if We renew this policy past Your age [65], the Maximum Benefit Period is one year.

Mental/Nervous Disorder means any disorder listed in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, most current as of the date of disability, published by the American Psychiatric Association, excluding Alzheimer's disease, dementia, and organic brain damage caused by an accident or head trauma. If the DSM is discontinued or replaced, Mental/Nervous Disorder will include those disorders listed in the diagnostic manual then in use by the American Psychiatric Association as of the date of disability, excluding Alzheimer's disease, dementia and organic brain damage caused by an accident or head trauma.

Monthly Income means Your monthly gross income earned from Your occupation including salary, wages, bonuses, commissions, fees and other pay for personal services. If You are self-employed or own a business, Monthly Income means Your share of gross income earned by the business, plus any salary or draw from the business, minus Your share of normal and customary business expenses specified as deductible for tax purposes.

Own Occupation means the occupation in which You are engaged at the time Your disability begins. If You are unemployed one year or less from the time Your disability begins, Own Occupation will be the occupation in which You were engaged prior to becoming unemployed. If You have been unemployed for more than one year, Own Occupation will be an occupation which fits You by education, training or experience.

Partial Disability and **Partially Disabled** mean a degree of disability due to a Sickness or Injury which:

- starts while this policy is in force;
- requires a Physician's care unless Your Physician certifies You have reached the maximum point of recovery;
- for the first two years after the Elimination Period, keeps You from doing one or more, but not all, of the substantial and material duties of Your Own Occupation or results in the loss of 25% or more of the time spent by You in the usual daily performance of the duties of Your Own Occupation; and
- after Total Disability and any Partial Disability benefits have been paid for two years, keeps You from doing one or more, but not all, of the substantial and material duties of Any Gainful Occupation or results in the loss of 25% or more of the time spent by You in the usual daily performance of the duties of Any Gainful Occupation.

Physician means a doctor of medicine or osteopathy who is duly licensed by the state medical board. Such Physician cannot be a member of Your Immediate Family or business associate and must be providing services within the scope of his or her license/specialty. Practitioners other than those named above are not Physicians.

Pre-existing Condition means a Sickness or physical condition for which, during the two years before the Issue Date, You:

- had symptoms which would cause an ordinary prudent person to seek diagnosis, care or treatment; or
- received medical consultation, advice or treatment from a Physician or had taken prescribed medication.

Presumptively Disabled means Your permanent and irrevocable loss, because of Your Injury or Sickness, of one of the following:

- speech;
- hearing in both ears;
- sight in both eyes;
- use of both feet;
- use of both hands; or
- use of one hand and one foot.

Permanent and irrevocable loss of sight means both of Your eyes measure at or below 20/200 after reasonable effort has been made to correct Your vision using the most advanced medically acceptable procedures and devices available. Permanent and irrevocable loss of hearing means hearing in both ears cannot be restored by hearing aids. You will be considered Totally Disabled if You are Presumptively Disabled.

Prior Monthly Income means the greater of:

- Your average Monthly Income for the one year period immediately prior to Your disability; or
- Your average Monthly Income for the calendar year with the highest earnings of the last two calendar years prior to Your disability.

Recurrent Total Disability means a situation in which You become Totally Disabled, cease to be Totally Disabled, then become Totally Disabled again from the same or related Sickness or Injury. The latter Total Disability will be considered a Recurrent Total Disability.

Reinstatement Date means the date We have both approved Your reinstatement application and received any premiums due.

Sickness means an illness, disease or physical condition.

Substance Abuse means drug abuse, alcoholism, or chemical dependency.

Total Disability and **Totally Disabled** mean a disability due to Sickness or Injury which:

- starts while this policy is in force;
- requires a Physician's care unless Your Physician certifies You have reached the maximum point of recovery;
- for the first two years after the Elimination Period, keeps You from doing all the substantial and material duties of Your Own Occupation; and
- after benefits have been paid for two years, keeps You from doing all the substantial and material duties of Any Gainful Occupation.

If You are able to perform one or more of the substantial and material duties of Your Own Occupation for the first two years after the Elimination Period, or of Any Gainful Occupation after benefits have been paid for two years, then You are not Totally Disabled.

We, Us and **Our** mean Assurity Life Insurance Company.

You and **Your** mean the insured person listed on the Policy Schedule.

PREMIUMS

Premium Payments. The first premium is due on the Issue Date. Premiums will include rider premiums, if any. Premiums paid after the first premium are renewal premiums. We may change the renewal premiums as provided on Page 1.

The date renewal premiums are due is called the due date. Except as provided under the grace period, this policy will lapse if a renewal premium is not paid by the due date. All premiums are considered paid when they are received at Our administrative office.

Grace Period. Your premium must be paid on or before the due date or during the 31-day grace period that follows the due date. This policy stays in force during this time. The grace period does not apply if You request termination of this policy.

Reinstatement. If You do not pay Your premium by the end of the grace period, this policy will lapse (will not be in force). If You want this policy reinstated (to be in force again), You must apply for reinstatement within one year of the lapse in writing to Our administrative office. Your application for reinstatement requires Our approval. If Your application for reinstatement is approved, this policy may be reinstated with payment of any premium due. This policy will be reinstated on the Reinstatement Date. If We have not already acted to approve or decline Your application for reinstatement, this policy will be reinstated without approval 45 days after You apply for reinstatement.

The reinstated policy shall cover disabilities resulting from such Injury as may be sustained after the Reinstatement Date. The reinstated policy shall also cover disabilities due to such Sickness as may begin more than 10 days after the Reinstatement Date.

Refund of Unearned Premium. If this policy terminates due to death, We will refund, on a pro-rata basis, the portion of any premiums paid which were applied to periods following the date of Your death.

TOTAL DISABILITY BENEFIT

Monthly Benefit Payment. We will pay the Total Disability Monthly Benefit shown on the Policy Schedule if You are Totally Disabled and the Elimination Period has been satisfied. We will only pay Total Disability Monthly Benefits while You are Totally Disabled or to the end of the Maximum Benefit Period, whichever is first. Total Disability Monthly Benefits will be paid for only one of two or more Concurrent Disabilities. A Total Disability from the same Sickness or Injury is subject to one Maximum Benefit Period.

A Recurrent Total Disability is considered a new Total Disability only if it is separated from the ending date of the prior Total Disability by a period of one year or more where You are continuously Employed on a Full-Time Basis and not receiving any disability monthly benefits under this policy or any riders. A new Total Disability is subject to a new Elimination Period and starts a new Maximum Benefit Period. Any other Recurrent Total Disability is considered a continuation of a prior Total Disability. A continuation of a prior Total Disability is not subject to a new Elimination Period, nor does it result in the start of a new Maximum Benefit Period.

Total Disability for Part of a Month. If Your Total Disability is payable for a period less than a full month, We will pay one-thirtieth (1/30) of the Total Disability Monthly Benefit for each day of Total Disability.

PARTIAL DISABILITY BENEFIT

Monthly Benefit Payment. We will pay You the Partial Disability Monthly Benefit shown on the Policy Schedule if You are Partially Disabled and have resumed part-time employment immediately following a period where You received Total Disability Monthly Benefits. Partial Disability payments count toward the Maximum Benefit Period and shall not be paid for a period greater than six months. Partial Disability Monthly Benefits will be paid for only one of two or more Concurrent Disabilities.

Partial Disability for Part of a Month. If Your Partial Disability is payable for a period less than a full month, We will pay one-thirtieth (1/30) of the Partial Disability Monthly Benefit for each day of Partial Disability.

PRESUMPTIVE DISABILITY BENEFIT

We will pay You the Total Disability Monthly Benefit for the Maximum Benefit Period if You are Presumptively Disabled. Benefits will be paid regardless of Your ability to work and whether or not You are under the care of a Physician. The Elimination Period does not need to be satisfied for You to receive this benefit.

HOME MODIFICATION BENEFIT

If You are Totally Disabled and have been receiving Total Disability Monthly Benefits for six consecutive months, We will pay actual costs, up to a maximum of six times the Total Disability Monthly Benefit during Your lifetime towards modification of Your existing residence to accommodate Your disability. Modifications must improve Your access to or Your use of facilities in Your existing residence and begin while You are Totally Disabled.

SURVIVOR BENEFIT

If You die while You are receiving Total Disability Monthly Benefits and have been receiving Total Disability Monthly Benefits for at least the prior 12 consecutive months, We will pay the beneficiary a lump sum of six times the Total Disability Monthly Benefit.

Survivor Benefit Beneficiary. The beneficiary as designated on the application is either a primary or contingent beneficiary. The primary beneficiary's interest in any survivor benefit is superior to and exclusive of the contingent beneficiary's interest. Survivor benefits are payable to the contingent beneficiary only if no primary beneficiary survives You. If there is no surviving beneficiary named in the application or later endorsement, any survivor benefit will be paid to Your estate.

VOCATIONAL REHABILITATION BENEFIT

If You are Totally Disabled and have been receiving Total Disability Monthly Benefits for six consecutive months, We will consider paying the actual costs of a vocational rehabilitation program up to a maximum of six times the Total Disability Monthly Benefit during Your lifetime. The program must be pre-approved by Us and provide instruction or training at an accredited college, university or vocational school that contributes to Your return to work. Participation is voluntary and may be at Your request or as suggested by Us.

WAIVER OF PREMIUM

We will begin to waive payment of Your renewal premiums on the first premium due date after You have been Totally Disabled for the Elimination Period or 90 days, whichever is shorter. Any premiums paid during this period which became due after Your Total Disability started will be refunded. Waiver of premium ends when You are no longer receiving disability monthly benefits under this policy or any rider. Premiums are not waived during a period of Partial Disability.

LIMITATIONS

Foreign Travel and Residency. We will pay up to a maximum of three disability monthly benefits for any disability sustained or continued outside the United States or Canada.

Mental/Nervous Disorders; Substance Abuse. We will pay up to a maximum of 24 disability monthly benefits during Your lifetime for disabilities due to Mental/Nervous Disorders and Substance Abuse.

Pre-existing Condition. If Your disability is within two years from the Issue Date and is due to a Pre-existing Condition, no benefits will be paid unless the condition was disclosed and not misrepresented on Your application and is not excluded by a policy amendment rider.

EXCLUSIONS

We will not pay benefits for conditions that are caused by or the result of You:

- being pregnant, experiencing childbirth or having an elective abortion (Complication of Pregnancy is deemed to be a Sickness);
- losing an occupational or professional license or certification;
- being exposed to war or any act of war, declared or undeclared;
- engaging in an illegal occupation;
- participating in or attempting to commit a felony;
- intentionally self-inflicting a Sickness or Injury;
- committing or attempting to commit suicide, while sane or insane;
- being incarcerated or is caused while incarcerated in a penal institution or government detention facility;
- being intoxicated (as determined by the laws governing the operation of motor vehicles in the jurisdiction where the disability occurs) or under the influence of an illegal substance or a narcotic (except for narcotics used as prescribed to You by a Physician); or
- actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserves, except during the active duty training of less than 60 days.

MILITARY SERVICE

This policy may be suspended if You enter active military service. Active military service means actively serving in any armed forces of any country, or unit auxiliary thereto, including the National Guard or Reserve, except for active duty training of less than 60 days. Upon Your written request for policy suspension due to active military service, We will refund the unearned premium on a pro-rata basis and suspend this policy.

You can put this policy back in force without providing evidence of insurability upon termination of such service. To do this, We will need Your written request and payment of renewal premium within 90 days of Your termination of active military service. The renewal premium will be the same as if this policy had stayed in force. This policy will be considered unsuspended and back in force under the conditions of this provision on the date We are in receipt of both Your written request to do so and payment of renewal premium. Once unsuspended, this policy shall cover disabilities resulting from such Injuries as may be sustained after this policy is put back in force and disabilities due to such Sickness as may begin more than 10 days after this policy is put back in force.

TERMINATION

Coverage will terminate and no benefits will be payable under this policy or any attached riders on the earliest of the following:

- when any premium due for this policy is not paid before the end of the grace period;
- the date We receive Your written request at Our administrative office to terminate coverage unless Your request specifies a later date;
- upon Your death; or
- the policy anniversary following Your age [65] or, if You continue to be Employed on a Full-time Basis after age [65], the policy anniversary following the date You cease being Employed on a Full-Time Basis. However, in no case shall coverage extend past the policy anniversary following Your age 75.

CLAIMS PROCEDURE

Notice of Claim. Written notice of claim must be given to Us within 20 calendar days after the loss covered by this policy starts. If notice is not given within that time, it must be given as soon as reasonably possible. Notice must be received at Our administrative office at Assurity Life Insurance Company, P.O. Box 82533, Lincoln, Nebraska 68501-2533. It should include Your name and policy number as shown on the Policy Schedule.

Claim Forms. When We receive the notice of claim, We will send You forms for filing proof of loss. If these forms are not sent to You within 15 calendar days, it shall be deemed that You met the proof of loss requirement by giving Us a written statement of the cause, nature and extent of the loss within the time limit as provided under Proof of Loss.

Proof of Loss. Written proof of loss must be given to Us within 120 calendar days after such loss. If it is not possible to give written proof in the time required, We will not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than one year from the time of loss unless You were legally incapacitated. While You are receiving disability benefits, We may periodically require You to submit additional documentation of Your disability at Your expense.

Time of Payment of Claims. Benefits for any loss covered by this policy will be paid immediately after proper written proof of loss is received. We will pay the Monthly Benefit Amount at the end of the month for which it is due.

Time of Loss. Benefits will be paid only for a loss which occurs while this policy is in force. Termination of this policy will not affect any claim for disability, provided that:

- Your disability begins within 30 days after the date of the Sickness or Injury causing Your disability; and
- Your Sickness or Injury occurs while this policy is in force.

Payment of Claims. At the time of claim payment, any premium then due and unpaid may be deducted by Us from the claim payment. Benefits, other than the survivor benefit, will be paid to You or Your estate. If benefits are payable to Your estate, We may pay up to $1,000 to any relative of Yours who We find is entitled to it. Any payment made in good faith will fully discharge Us to the extent of the payment.

GENERAL PROVISIONS

Application Statements. No statement will void this policy or any attached riders, or be used to defend a claim unless You made the statement in Your application. We can only use application statements if We attach a copy of Your application to this policy.

State law also requires Us to inform You that the statements You make in Your application are deemed representations and not warranties. Representations are statements that, to the best of Your knowledge and understanding, represent the truth. Warranties are statements that are guaranteed to be true. If We considered Your statements as warranties, We could cancel this policy for any inaccuracy – even an honest mistake. Therefore, We regard the statements made in Your application as representations, not as warranties.

Assignment. You can transfer, or assign, some or all of Your policy rights to someone else by making a contract with that person. We are not responsible for the validity of any assignment of this policy, nor are We bound by any assignment until We receive a copy of the assignment at Our administrative office.

Change of Beneficiary. The beneficiary is named in the application or later endorsement. You may change the beneficiary by completing and signing a form provided by Us for changing a beneficiary and returning the form to Our administrative office for Our written acknowledgement.

Naming a new beneficiary voids any prior designation unless stated otherwise in the new designation.

When We furnish You written acknowledgement of the change of beneficiary, the change becomes effective on the date You signed Our form. We are not liable for payment made or action taken prior to Our written acknowledgement of the beneficiary change.

Conformity with State Statutes. The law of Your state of residence on the Issue Date applies. If this policy conflicts with Your state's laws on the Issue Date, it is considered changed to meet those laws. The change will be to the law's minimum requirement.

Entire Contract; Changes. The entire contract between You and Us includes:

- this policy, which is the contract of insurance;
- Your application and any attached papers; and
- any riders, endorsements or amendments attached to this policy.

No change in this policy will be effective until approved by one of Our officers and unless such approval be endorsed on and attached to this policy. No sales representative has authority to change this policy or to waive any of its provisions.

Legal Action. You cannot bring a legal action to recover benefits under this policy for at least 60 days after You have given Us written proof of loss. You cannot start such an action more than three years after the date proof of loss is required.

Misstatement of Age and/or Gender. If Your age and/or gender has been misstated, an adjustment in premiums, coverage, or both, will be made based on Your correct age and/or gender. If, according to Your correct age, the coverage provided by this policy would not have become effective, or would have ceased, Our only liability during the period in which You were not eligible for coverage, shall be limited to the refund, upon written request to Our administrative office, of premiums paid for such period.

Misstatement of Income. If Your Monthly Income was overstated at the time of policy application, an adjustment in both coverage and premiums may be made. If, according to Your correct income, the coverage provided by this policy would not have become effective, Our liability shall be limited to the refund, upon written request to Our administrative office, of premiums paid.

Periods of Time. All periods of time shown in this policy begin and end at 12:01 a.m. in the standard time zone of Your permanent residence.

Physical Examination and Autopsy. We have the right to have You examined when and as often as is reasonable while a claim is pending and to have an autopsy performed where it is not forbidden by law. If We initiate the request, either or both will be done at Our expense.

Time of Coverage. Coverage starts on this policy's Issue Date at 12:01 a.m., in the standard time zone of Your permanent residence. It ends at 12:01 a.m. of the same standard time zone on the renewal date, subject to the grace period. This policy may be renewed only as stated in the Renewal section. Each time this policy is renewed, the new term begins when the old term ends.

Time Limit on Certain Defenses. After three years from the Issue Date of this policy, excluding any time You were Totally Disabled, We cannot use misstatements, except fraudulent misstatements, in Your application to void coverage or deny a claim for loss that happens after the three-year period.

After three years from Your last Reinstatement Date, excluding any time You were Totally Disabled, We cannot use misstatements, except fraudulent misstatements, in Your reinstatement application to void coverage or deny a claim for loss that happens after the three-year period.

No claim for loss incurred or disability commencing after three years from the Issue Date of this policy, shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

DISABILITY INCOME POLICY

Guaranteed Renewable to Age [65] • Qualified Right to Renew to Age 75
Company may change premium rates

READ YOUR POLICY CAREFULLY

ASSURITY LIFE INSURANCE COMPANY
P.O. Box 82533, Lincoln, Nebraska 68501-2533
(800) 869-0355

DISABILITY INCOME POLICY
OUTLINE OF COVERAGE

A. READ YOUR POLICY CAREFULLY! This Outline of Coverage provides a very brief description of the important features of Your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both You and Us. It is, therefore, important that You **READ YOUR POLICY CAREFULLY.**

B. Disability income coverage is designed to provide You with Coverage for disabilities resulting from a Covered Accident or Sickness or combination thereof. Coverage is provided for the benefits described in the BENEFITS section below. The benefits described may be limited as outlined in the LIMITATIONS and EXCLUSIONS sections.

C. BENEFITS

TOTAL DISABILITY BENEFIT

Monthly Benefit Payment. We will pay the Total Disability Monthly Benefit shown on the Policy Schedule if You are Totally Disabled as defined in Your policy and the Elimination Period has been satisfied. We will pay the Total Disability Monthly Benefit for only one of two or more Concurrent Disabilities. Total Disability Monthly Benefits continue while You are Totally Disabled or until the end of the Maximum Benefit Period, whichever is first.

Total Disability for Part of a Month. If Your Total Disability is payable for a period less than a full month, We will pay one-thirtieth (1/30) of the Total Disability Monthly Benefit for each day of Total Disability.

PARTIAL DISABILITY BENEFIT

Monthly Benefit Payment. We will pay the Partial Disability Monthly Benefit shown on the Policy Schedule if You are Partially Disabled. Partial Disability payments count toward the Maximum Benefit Period and shall not be paid for a period greater than six months.

Partial Disability for Part of a Month. If Your Partial Disability is payable for a period less than a full month, We will pay one-thirtieth (1/30) of the Partial Disability Monthly Benefit for each day of Partial Disability.

PRESUMPTIVE DISABILITY BENEFIT

We will pay the Total Disability Monthly Benefit for the Maximum Benefit Period if You are Presumptively Disabled. Benefits will be paid regardless of Your ability to work and whether or not You are under the care of a Physician. The Elimination Period does not need to be satisfied for You to receive this benefit.

HOME MODIFICATION BENEFIT

If You are Totally Disabled and have been receiving Total Disability Monthly Benefits for six consecutive months, We will pay actual costs, up to a maximum of six times the Total Disability Monthly Benefit during Your lifetime towards modification of Your existing residence to accommodate Your disability. Modifications must improve Your access to or Your use of facilities in Your existing residence and begin while You are Totally Disabled.

SURVIVOR BENEFIT
If You die while You are receiving Total Disability Monthly Benefits and have been receiving Total Disability Monthly Benefits for at least the prior 12 consecutive months, We will pay the beneficiary a lump sum of six times the Total Disability Monthly Benefit.

VOCATIONAL REHABILITATION BENEFIT
If You are Totally Disabled and have been receiving Total Disability Monthly Benefits for six consecutive months, We will consider paying the actual costs of a vocational rehabilitation program up to a maximum of six times the Total Disability Monthly Benefit during Your lifetime. The program must be pre-approved by Us and provide instruction or training at an accredited college, university or vocational school that contributes to Your return to work. Participation is voluntary and may be at Your request or as suggested by Us.

WAIVER OF PREMIUM
We will begin to waive payment of Your renewal premiums on the first premium due date after You have been Totally Disabled for the Elimination Period or 90 days, whichever is shorter. Any premiums paid during this period which became due after Your Total Disability started will be refunded. Waiver of premium ends when You are no longer receiving disability monthly benefits under this policy or any rider. Premiums are not waived during a period of Partial Disability.

D. LIMITATIONS

Foreign Travel and Residency. We will make up to three disability monthly benefit payments for any disability sustained or continued outside the United States or Canada.

Mental/Nervous Disorders; Substance Abuse. We will pay up to a maximum of 24 disability monthly benefits during Your lifetime for disabilities due to Mental/Nervous Disorders and Substance Abuse.

Pre-existing Condition. If Your disability is within two years from the Issue Date and is due to a Pre-existing Condition, no benefits will be paid unless the condition was disclosed and not misrepresented on Your application and is not excluded by a policy amendment rider.

E. EXCLUSIONS

We will not pay benefits for conditions that are caused by or the result of You:

- being pregnant, experiencing childbirth or having an elective abortion (Complication of Pregnancy is deemed to be a Sickness);
- losing an occupational or professional license or certification;
- being exposed to war or any act of war, declared or undeclared;
- engaging in an illegal occupation;
- participating in or attempting to commit a felony;
- intentionally self-inflicting a Sickness or Injury;
- committing or attempting to commit suicide, while sane or insane;
- being incarcerated or is caused while incarcerated in a penal institution or government detention facility;
- being intoxicated (as determined by the laws governing the operation of motor vehicles in the jurisdiction where the disability occurs) or under the influence of an illegal substance or a narcotic (except for narcotics used as prescribed to You by a Physician); or
- actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserves, except during the active duty training of less than 60 days.

F. MILITARY SERVICE

Your policy may be suspended if You enter active military service. Active military service means actively serving in any armed forces of any country, or unit auxiliary thereto, including the National Guard or Reserve,

except for active duty training of less than 60 days. Upon Your written request for policy suspension due to active military service, We will refund the unearned premium on a pro-rata basis and suspend Your policy.

You can put Your policy back in force without providing evidence of insurability upon termination of such service. To do this, We will need Your written request and payment of renewal premium within 90 days of Your termination of active military service. The renewal premium will be the same as if Your policy had stayed in force. Your policy will be considered unsuspended and back in force under the conditions of this provision on the date We are in receipt of both Your written request to do so and payment of renewal premium. Once unsuspended, Your policy shall cover disabilities resulting from such Injuries as may be sustained after Your policy is put back in force and disabilities due to such Sickness as may begin more than 10 days after Your policy is put back in force.

G. RENEWABILITY

This policy is guaranteed renewable to age [65]. That means as long as You pay premiums when due, We cannot cancel or change Your policy. If You are over age [65], You must be Employed on a Full-Time Basis to renew Your policy on each policy anniversary to age 75. After age [65], the Maximum Benefit Period is limited to one year, and Your premium will change on each policy anniversary.

H. PREMIUMS

We reserve the right to change the premium rates. If We do this, We can only do it after approval or acknowledgement by Your state for all policies in Your class. You will be given 31 days notice by mail prior to any premium change.

I. OPTIONAL BENEFIT RIDERS

[5-Year] Own Occupation Rider – This rider changes the definition of Total Disability; Totally Disabled in Your policy to read as follows:

Total Disability and **Totally Disabled** mean a disability due to Sickness or Injury which:

- starts while this policy is in force;
- requires a Physician's care unless Your Physician certifies You have reached the maximum point of recovery; [and]
- [for the first five years] after the Elimination Period, keeps You from doing all the substantial and material duties of Your Own Occupation[; and
- after benefits have been paid for five years, keeps You from doing all the substantial and material duties of Any Gainful Occupation].

If You are able to perform one or more of the substantial and material duties of Your Own Occupation [during the first five years] after the Elimination Period, [or of Any Gainful Occupation after benefits have been paid for five years,] then You are not Totally Disabled.

Automatic Benefit Increase Rider – This rider increases Your Total Disability Monthly Benefit by 5% of the original Total Disability Monthly Benefit each year for any benefits starting after the first year of continuous Total Disability Monthly Benefits have been paid. Payment of the Total Disability Monthly Benefit is subject to all policy provisions. Payments will continue to increase each year while payable under Your policy until the Total Disability Monthly Benefit payment has increased to twice the original amount as shown on the Policy Schedule.

Catastrophic Disability Benefit Rider – We will pay the Catastrophic Disability Monthly Benefit if You are Catastrophically Disabled and all of the Total Disability Monthly Benefits under Your policy have been paid. We will only pay benefits while You are Catastrophically Disabled or to the end of the Maximum Catastrophic Benefit Period, whichever is first, subject to the Limitations section of Your policy.

Critical Illness Benefit Rider - We will pay this benefit if You receive a First Ever Diagnosis or Procedure for one of the Specified Critical Illnesses shown in the chart below if:

- the Date of Diagnosis is while coverage under this rider is in force; and
- the Specified Critical Illness is not excluded by name or specific description in this rider.

The amount payable for each First Ever Diagnosis or Procedure of a Specified Critical Illness is the percentage of the Benefit Amount multiplied by the Benefit Amount. The Benefit Amount is shown on the rider Schedule. The percentage of the Benefit Amount payable for each Specified Critical Illness is shown beside the illness in the chart below.

The maximum total percentage of the Benefit Amount payable per category of Specified Critical Illnesses is shown in the last column of the chart below.

Category	Specified Critical Illness	Percentage of Benefit Amount Payable for each Specified Critical Illness	Maximum Percentage of Benefit Amount for Category
Category 1	Heart Attack	100%	100%
	Major Organ Transplant – heart or combination transplant including heart	100%	
	Stroke	100%	
	Coronary Bypass Surgery	25%	
	Angioplasty	10%	
Category 2	Kidney (Renal) Failure	100%	100%
	Major Organ Transplant – not covered in Category 1	100%	
	Paralysis – not as a result of Stroke	100%	
Category 3	Invasive Cancer	100%	100%
	Carcinoma in situ	25%	

If an Insured Person receives a percentage of the Benefit Amount for one Specified Critical Illness within a category in the chart above and then becomes eligible for benefits for another Specified Critical Illness within the same category, the Benefit Amount payable for the subsequent illness within the same category is the lesser of the percentage amount payable or 100% minus the percentage of the Benefit Amount received for all previous Specified Critical Illnesses within the same category.

After 100% of the Benefit Amount shown on the rider Schedule has been paid for an Insured Person within a category in the chart above, We will not pay any additional benefits for any Specified Critical Illness in that category for that Insured Person. We will pay the benefit for Coronary Bypass Surgery, Carcinoma in situ and Angioplasty only once per lifetime per Insured Person.

If benefits have been paid for a Specified Critical Illness within one category for an Insured Person, no benefits will be payable for a subsequent Specified Critical Illness within a different category for that Insured Person unless the Date of Diagnosis of the subsequent Specified Critical Illness is separated by at least 180 days from the Date of Diagnosis of the immediately preceding Specified Critical Illness.

If You receive benefits for Carcinoma in situ and are later Diagnosed with Invasive Cancer, the remaining Benefit Amount will be paid.

Guaranteed Insurability Rider – This rider gives You the option to increase Your Total Disability Monthly Benefit by purchasing additional amounts of insurance. Each Increase Amount requested must be in $100 increments for at least $200 up to the Maximum Increase Amount. Additional amounts of insurance will have the same Benefit Period and Elimination Period as Your policy.

Non-Cancelable Rider – This rider makes Your policy and riders Non-Cancelable, which means that We cannot change the policy or riders by increasing the premiums or cancelling prior to termination.

Residual Disability Benefit Rider – We will pay a Residual Disability Monthly Benefit if You are Residually Disabled and the Elimination Period shown in the Rider Schedule has been satisfied by any continuous period of Total and/or Residual Disability. We will only pay benefits while You are Residually Disabled or to the end of the Maximum Residual Benefit Period, whichever is first.

Retroactive Injury Benefit Rider – We will pay the Retroactive Injury Benefit if an Injury causes You to become Totally Disabled within 30 days of such Injury, and You are continuously Totally Disabled from the date of Your Injury until the end of the Elimination Period shown on the Policy Schedule. The benefit is a lump sum amount equal to the Total Disability Monthly Benefit shown on the Policy Schedule times the number of days in the Elimination Period divided by 30. We will pay the benefit at the end of the Elimination Period.

Return of Premium Benefit Rider – This rider provides for a Return of Premium Benefit, which is equal to the benefit as defined in the Rider Benefit Calculation section.

Supplemental Disability Income Rider – We will pay the Supplemental Disability Income Monthly Benefit less any Social Insurance Benefits received if You are Totally Disabled and the Elimination Period has been satisfied. We will only pay benefits while you are Totally Disabled or to the end of the Maximum Supplemental Benefit Period, whichever is first. No benefits will be paid if Social Insurance Benefits exceed the Supplemental Disability Income Monthly Benefit amount.

Assurity
Life Insurance Company

[5-YEAR] OWN OCCUPATION RIDER

This rider is attached to and part of Your policy. The terms of Your policy apply to this rider unless otherwise stated in this rider. This rider is issued in return for Your approved application and the Initial Premium. Premium for this rider is included in the Initial Premium shown on the Policy Schedule. Rider premiums are paid to Our administrative office at the same time as policy premiums. We can change the premium rates. If We change the premium rates, We can only do it after approval or acknowledgement by Your state for all insured persons in Your class. You will be given 31 days notice by mail prior to any premium change.

RIDER SCHEDULE

Insured Person	[	]
Issue Date	[	]

RIDER BENEFIT

This rider changes the definition of Total Disability; Totally Disabled in Your policy to read as follows:

Total Disability and **Totally Disabled** mean a disability due to Sickness or Injury which:

- starts while this policy is in force;
- requires a Physician's care unless Your Physician certifies You have reached the maximum point of recovery; [and]
- [for the first five years] after the Elimination Period, keeps You from doing all the substantial and material duties of Your Own Occupation[; and
- [after benefits have been paid for five years, keeps You from doing all the substantial and material duties of Any Gainful Occupation].

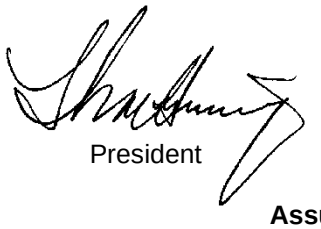
If You are able to perform one or more of the substantial and material duties of Your Own Occupation [during the first five years] after the Elimination Period, [or of Any Gainful Occupation after benefits have been paid for five years,] then You are not Totally Disabled.

TERMINATION

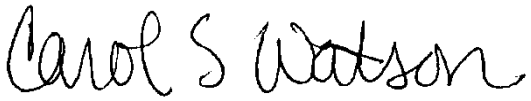
Coverage will terminate and no benefits will be payable under this rider on the earliest of the following:

- the date Your policy terminates for any reason;
- when any premium due for this rider is not paid before the end of the grace period;
- the date We receive Your written request at Our administrative office to terminate this rider unless Your request specifies a later date; or
- the policy anniversary following Your age [65].

Assurity Life Insurance Company has signed this rider on the Issue Date.



President



Secretary

Assurity Life Insurance Company
Administrative Office
P.O. Box 82533 - Lincoln, Nebraska 68501-2533
Toll-free (800) 869-0355

Assurity
Life Insurance Company

AUTOMATIC BENEFIT INCREASE RIDER

This rider is attached to and part of Your policy. The terms of Your policy apply to this rider unless otherwise stated in this rider. This rider is issued in return for Your approved application and the Initial Premium. Premium for this rider is included in the Initial Premium shown on the Policy Schedule. Rider premiums are paid to Our administrative office at the same time as policy premiums. We can change the premium rates. If We change the premium rates, We can only do it after approval or acknowledgement by Your state for all insured persons in Your class. You will be given 31 days notice by mail prior to any premium change.

RIDER SCHEDULE

Insured Person	[	]
Issue Date	[	]

RIDER BENEFIT

This rider increases Your Total Disability Monthly Benefit by 5% of the original Total Disability Monthly Benefit each year for any benefits payable starting after the first year of continuous Total Disability Monthly Benefits have been paid. Payment of the Total Disability Monthly Benefit is subject to all policy provisions. Payments will continue to increase each year while payable under Your policy until the Total Disability Monthly Benefit payment has increased to twice the original amount as shown on the Policy Schedule.

The increases do not apply to any riders attached to the policy.

RIGHT TO INCREASE MONTHLY BENEFIT

If You are receiving an increased Total Disability Monthly Benefit and recover from Your Total Disability, You may increase Your Total Disability Monthly Benefit to the amount of Your last Total Disability Monthly Benefit payment. To receive the increase, You must:

- be under attained age 60;
- make a written request to Our administrative office for the increase within 90 days of the end of Your Total Disability; and
- confirm that You are Employed on a Full-Time Basis.

A new premium will be charged for the amount of increased Total Disability Monthly Benefit. This premium will be based on Our then current rates and Your attained age.

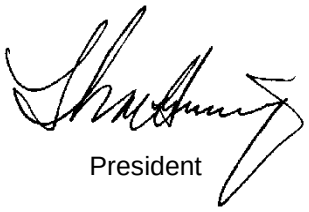
If You do not exercise Your right to increase Your Total Disability Monthly Benefit, benefits will remain as shown on the Policy Schedule page.

TERMINATION

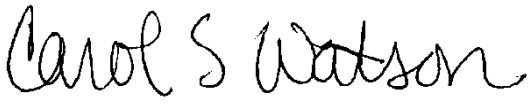
Coverage will terminate and no benefits will be payable under this rider on the earliest of the following:

- the date Your policy terminates for any reason;
- when any premium due for this rider is not paid before the end of the grace period;
- the date We receive Your written request at Our administrative office to terminate this rider unless Your request specifies a later date; or
- the policy anniversary following Your age [65].

Assurity Life Insurance Company has signed this rider on the Issue Date.



President



Secretary

Assurity Life Insurance Company
Administrative Office
P.O. Box 82533 - Lincoln, Nebraska 68501-2533
Toll-free (800) 869-0355

Assurity
Life Insurance Company

CATASTROPHIC DISABILITY BENEFIT RIDER

This rider is attached to and part of Your policy. The terms of Your policy apply to this rider unless otherwise stated in this rider. This rider is issued in return for Your approved application and the Initial Premium. Premium for this rider is included in the Initial Premium shown on the Policy Schedule. Rider premiums are paid to Our administrative office at the same time as policy premiums. We can change the premium rates. If We change the premium rates, We can only do it after approval or acknowledgement by Your state for all insured persons in Your class. You will be given 31 days notice by mail prior to any premium change.

RIDER SCHEDULE

Insured Person	[ ]
Issue Date	[ ]
Catastrophic Disability Monthly Benefit	[$]
Maximum Catastrophic Benefit Period	[ ]

DEFINITIONS

Activities of Daily Living (ADLs) means certain basic daily tasks necessary to maintain Your health and safety. In this rider, ADLs refer to the activities described below:

- ***Bathing*** means washing oneself by sponge bath; or in either a tub or shower including the task of getting into or out of the tub or shower.
- ***Continence*** means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
- ***Dressing*** means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
- ***Eating*** means feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.
- ***Toileting*** means getting to and from the toilet, transferring on and off the toilet and performing associated personal hygiene.
- ***Transfer and Mobility*** means the ability to move into or out of a bed, chair or wheelchair or to move from place to place, either via walking, a wheelchair, cane, crutches, walker or other equipment.

Catastrophic Disability and **Catastrophically Disabled** mean You are Totally Disabled past the Maximum Benefit Period of Your policy and:

- You need the presence of another person within arm's reach and/or physical assistance, to perform two or more Activities of Daily Living, or You are Cognitively Impaired;
- You do not work in any job for wage or profit; and
- a Physician has certified Your continued Total Disability and has prescribed a Plan of Treatment.

Cognitively Impaired means a deterioration or loss of ability to think, perceive, reason or remember which calls for another person's help or prompting to protect Yourself or others. It is measured by clinical evidence and standardized tests approved by Us that reliably measure such impairment. The loss in mental capacity must be a result of a Sickness or Injury, including Alzheimer's disease, dementia, and organic brain damage caused by an accident or head trauma.

Maximum Catastrophic Benefit Period means the maximum period of time the Catastrophic Disability Monthly Benefit is payable due to a Catastrophic Disability as shown in the Rider Schedule.

Plan of Treatment means a written plan prescribed by a Physician which outlines a sequence of treatment and/or procedures You need due to Your Catastrophic Disability.

RIDER BENEFIT

We will pay the Catastrophic Disability Monthly Benefit if You are Catastrophically Disabled and all of the Total Disability Monthly Benefits under Your policy have been paid. We will only pay benefits while You are Catastrophically Disabled or to the end of the Maximum Catastrophic Benefit Period, whichever is first, subject to the Limitations section of Your policy.

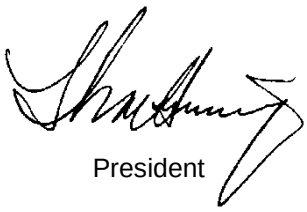
We will waive payment of renewal premiums. Waiver of premium ends when You are no longer receiving disability monthly benefits under this rider.

TERMINATION

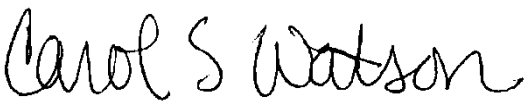
Coverage will terminate and no benefits will be payable under this rider on the earliest of the following:

- the date Your policy terminates for any reason;
- when any premium due for this rider is not paid before the end of the grace period;
- the date We receive Your written request at Our administrative office to terminate this rider unless Your request specifies a later date; or
- the policy anniversary following Your age [65].

Assurity Life Insurance Company has signed this rider on the Issue Date.



President



Secretary

Assurity Life Insurance Company
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P.O. Box 82533 - Lincoln, Nebraska 68501-2533
Toll-free (800) 869-0355

GUARANTEED INSURABILITY RIDER

This rider is attached to and part of Your policy. The terms of Your policy apply to this rider unless otherwise stated in this rider. This rider is issued in return for Your approved application and the Initial Premium. Premium for this rider is included in the Initial Premium shown on the Policy Schedule. Rider premiums are paid to Our administrative office at the same time as policy premiums. We can change the premium rates. If We change the premium rates, We can only do it after approval or acknowledgement by Your state for all insured persons in Your class. You will be given 31 days notice by mail prior to any premium change.

RIDER SCHEDULE

Insured Person	[	]
Issue Date	[	]
Maximum Increase Amount	$[	]

DEFINITIONS

Increase Amount means the amount by which Your Total Disability Monthly Benefit will be increased related to any one Option Date.

Option Date means an anniversary of the Issue Date. The first Option Date must be at least two years after the Issue Date. Each Option Date must be at least two years apart.

Option Period means the period beginning 60 days prior to any Option Date and ending on the Option Date.

RIDER BENEFIT

This rider gives You the option to increase Your Total Disability Monthly Benefit by purchasing additional amounts of insurance. Each Increase Amount requested must be in $100 increments for at least $200 up to the Maximum Increase Amount. Additional amounts of insurance will have the same Benefit Period and Elimination Period as Your policy.

You may exercise this option no more than five times before the anniversary following Your age 55. The sum of all Increase Amounts cannot exceed Your original Total Disability Monthly Benefit. Increases must be requested while this rider is in force and in writing to Our administrative office during an Option Period.

Increases do not require evidence of insurability but are based on Your current income and then current issue and participation limits from Our financial underwriting guidelines. When Your request is approved, the Increase Amount will become effective on the Option Date. The premium for the Increase Amount will be based on Our then current rates and Your attained age.

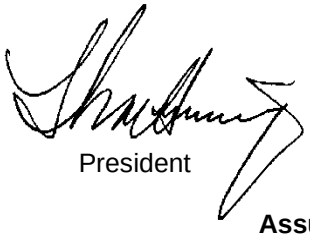
You cannot exercise an option if You are disabled or if You are receiving disability income benefits under Your policy or any attached riders.

TERMINATION

Coverage will terminate and no benefits will be payable under this rider on the earliest of the following:

- the date Your policy terminates for any reason;
- when any premium due for this rider is not paid before the end of the grace period;
- the date We receive Your written request at Our administrative office to terminate this rider unless Your request specifies a later date; or
- the policy anniversary following Your age 55.

Assurity Life Insurance Company has signed this rider on the Issue Date.



President

Secretary

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Assurity
Life Insurance Company

NON-CANCELABLE RIDER

This rider is attached to and part of Your policy. The terms of Your policy apply to this rider unless otherwise stated in this rider. This rider is issued in return for Your approved application and the Initial Premium. Premium for this rider is included in the Initial Premium shown on the Policy Schedule. Rider premiums are paid to Our administrative office at the same time as policy premiums.

RIDER SCHEDULE

Insured Person [ ]
Issue Date [ ]

DEFINITION

Non-Cancelable means that We cannot change the policy or riders by:

- increasing the premiums; or
- cancelling prior to termination.

RIDER BENEFIT

This rider makes Your policy and any attached riders Non-Cancelable.

TERMINATION

Coverage will terminate and no benefits will be payable under this rider on the earliest of the following:

- the date Your policy terminates for any reason;
- when any premium due for this rider is not paid before the end of the grace period;
- the date We receive Your written request at Our administrative office to terminate this rider unless Your request specifies a later date; or
- the policy anniversary following Your age [65].

Assurity Life Insurance Company has signed this rider on the Issue Date.

President

Carol S Watson
Secretary

Assurity Life Insurance Company
Administrative Office
P.O. Box 82533, Lincoln, Nebraska 68501-2533
Toll-free (800) 869-0355

Assurity
Life Insurance Company

RESIDUAL DISABILITY BENEFIT RIDER

This rider is attached to and part of Your policy. The terms of Your policy apply to this rider unless otherwise stated in this rider. This rider is issued in return for Your approved application and the Initial Premium. Premium for this rider is included in the Initial Premium shown on the Policy Schedule. Rider premiums are paid to Our administrative office at the same time as policy premiums. We can change the premium rates. If We change the premium rates, We can only do it after approval or acknowledgement by Your state for all insured persons in Your class. You will be given 31 days notice by mail prior to any premium change.

RIDER SCHEDULE

Insured Person	[	]	
Issue Date	[	]	
Maximum Residual Benefit Period	[	]	
Elimination Period	[	]	consecutive days

DEFINITIONS

Current Monthly Income means Your Monthly Income earned during a period of Residual Disability.

Elimination Period means the number of consecutive days You must be Totally or Residually Disabled before You are eligible to receive the benefits as shown on the Rider Schedule. We do not pay benefits during the Elimination Period.

Residual Disability and **Residually Disabled** mean a degree of disability due to Sickness or Injury which:

- starts while this rider is in force;
- requires a Physician's care unless Your Physician certifies You have reached the maximum point of recovery;
- results in Your loss of at least 20% of Your Prior Monthly Income;
- for the first two years after the Elimination Period, keeps you from doing one or more, but not all, of the substantial and material duties of Your Own Occupation; and
- after benefits have been paid for two years, keeps you from doing one or more, but not all, of the substantial and material duties of Any Gainful Occupation.

If You are Totally Disabled, You are not Residually Disabled.

RIDER BENEFIT

We will pay the Residual Disability Monthly Benefit if You are Residually Disabled and the Elimination Period shown in the Rider Schedule has been satisfied by any continuous period of Total and/or Residual Disability. We will only pay benefits while You are Residually Disabled or to the end of the Maximum Residual Benefit Period, whichever is first.

For each of the first six months of Residual Disability, We will pay the greater of the following:

- the Partial Disability Monthly Benefit; or
- the Residual Disability Monthly Benefit.

We will waive payment of renewal premiums during Your Residual Disability. We will begin to waive payment of Your renewal premiums on the first premium due date after You have been Totally and/or Residually Disabled for the Elimination Period or 90 days, whichever is shorter. Any premiums paid during this period which became due after Your disability started will be refunded. Waiver of premium ends when You cease to be Residually Disabled or at the end of the Maximum Residual Benefit Period, whichever is first.

RIDER BENEFIT CALCULATION

The Residual Disability Monthly Benefit is calculated as follows:

[(Prior Monthly Income – Current Monthly Income) / Prior Monthly Income] x Total Disability Monthly Benefit

In no event will the Residual Disability Monthly Benefit be greater than the Total Disability Monthly Benefit. If Your Residual Disability is payable for a period less than a full month, We will pay one-thirtieth (1/30) of the Residual Disability Monthly Benefit for each day of Residual Disability.

RIDER CONDITIONS

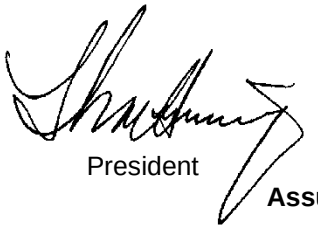
Proof of Monthly Income. We will require proof to determine Your Prior Monthly Income and Current Monthly Income. Proof may include Your Federal Income Tax Return(s) as filed with the Internal Revenue Service, monthly profit and loss statements, and earnings statements. At Our expense We may require an onsite accounting audit to verify proof of monthly income.

TERMINATION

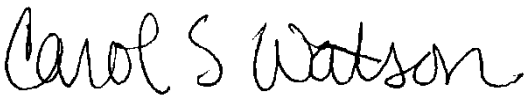
Coverage will terminate and no benefits will be payable under this rider on the earliest of the following:

- the date Your policy terminates for any reason;
- when any premium due for this rider is not paid before the end of the grace period;
- the date We receive Your written request at Our administrative office to terminate this rider unless Your request specifies a later date; or
- the policy anniversary following Your age [65].

Assurity Life Insurance Company has signed this rider on the Issue Date.



President



Secretary

Assurity Life Insurance Company
Administrative Office
P.O. Box 82533 - Lincoln, Nebraska 68501-2533
Toll-free (800) 869-0355

Assurity
Life Insurance Company

RETROACTIVE INJURY BENEFIT RIDER

This rider is attached to and part of Your policy. The terms of Your policy apply to this rider unless otherwise stated in this rider. This rider is issued in return for Your approved application and the Initial Premium. Premium for this rider is included in the Initial Premium shown on the Policy Schedule. Rider premiums are paid to Our administrative office at the same time as policy premiums. We can change the premium rates. If We change the premium rates, We can only do it after approval or acknowledgement by Your state for all insured persons in Your class. You will be given 31 days notice by mail prior to any premium change.

RIDER SCHEDULE

Insured Person [ ]
Issue Date [ ]

RIDER BENEFIT

We will pay the Retroactive Injury Benefit if an Injury causes You to become Totally Disabled within 30 days of such Injury, and You are continuously Totally Disabled from the date of Your Injury until the end of the Elimination Period shown on the Policy Schedule. The benefit is a lump sum amount equal to the Total Disability Monthly Benefit shown on the Policy Schedule times the number of days in the Elimination Period divided by 30. We will pay the benefit at the end of the Elimination Period.

This benefit does not apply to any riders attached to Your policy.

TERMINATION

Coverage will terminate and no benefits will be payable under this rider on the earliest of the following:

- the date Your policy terminates for any reason;
- when any premium due for this rider is not paid before the end of the grace period;
- the date We receive Your written at Our administrative office request to terminate this rider unless Your request specifies a later date; or
- the policy anniversary following Your age [65].

Assurity Life Insurance Company has signed this rider on the Issue Date.

President

Secretary

Assurity Life Insurance Company
Administrative Office
P.O. Box 82533, Lincoln, Nebraska 68501-2533
Toll-free (800) 869-0355

Assurity
Life Insurance Company

RETURN OF PREMIUM BENEFIT RIDER

This rider is attached to and part of Your policy. The terms of Your policy apply to this rider unless otherwise stated in this rider. This rider is issued in return for Your approved application and the Initial Premium. Premium for this rider is included in the Initial Premium shown on the Policy Schedule. Rider premiums are paid to Our administrative office at the same time as policy premiums. We can change the premium rates. If We change the premium rates, We can only do it after approval or acknowledgement by Your state for all insured persons in Your class. You will be given 31 days notice by mail prior to any premium change.

RIDER SCHEDULE

Insured Person [ ]
Issue Date [ ]

RIDER BENEFIT

This rider provides for a Return of Premium Benefit, which is equal to the benefit as defined in the Rider Benefit Calculation section.

We will pay the Return of Premium Benefit for the following:

- upon Your written request to Our administrative office to cancel Your policy;
- upon lapse of Your policy;
- upon receipt of proof of Your death; or
- on the policy anniversary following Your age [65].

If You terminate this rider and the policy stays in force, no Return of Premium Benefit will be paid. Any benefits payable under Your policy and attached riders where notification of claim was given after Your policy termination will be less any Return of Premium Benefit paid. If reinstatement of a lapsed policy is later requested and approved, any Return of Premium Benefits received by You must be repaid to Us as a condition of reinstatement.

RIDER BENEFIT CALCULATION

The following table shows the percentage of premium returned as of the completed policy year. The completed policy year is determined by Your policy Issue Date as shown on the Policy Schedule.

To determine the Return of Premium Benefit:

1. Add together all premiums paid for Your policy, all premiums paid for riders attached to Your policy and all premiums waived (excluding Critical Illness Benefit Rider premium paid and waived).
2. Multiply the amount calculated in 1 above by the percentage matching the appropriate completed policy year in the Return of Premium Benefit Schedule shown below.
3. Subtract from the amount calculated in 2 above, all benefits paid under Your policy and any riders (excluding Critical Illness Benefit Rider benefits paid).

The result of this calculation is the Return of Premium Benefit.

RETURN OF PREMIUM BENEFIT SCHEDULE

FOR APPLICANTS AGE 18 THROUGH 44

COMPLETED POLICY YEAR	RETURN PERCENTAGE	COMPLETED POLICY YEAR	RETURN PERCENTAGE	COMPLETED POLICY YEAR	RETURN PERCENTAGE
1	0%	9	36%	17	71%
2	0%	10	42%	18	74%
3	5%	11	47%	19	78%
4	8%	12	51%	20	82%
5	9%	13	56%	21	85%
6	13%	14	60%	22	89%
7	22%	15	63%	23	92%
8	30%	16	67%	24	96%
				25 & OVER	100%

FOR APPLICANTS AGE 45 THROUGH 55

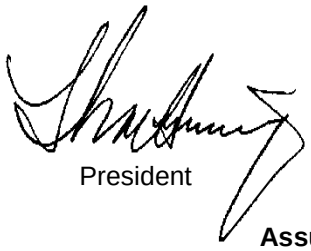
COMPLETED POLICY YEAR	RETURN PERCENTAGE	COMPLETED POLICY YEAR	RETURN PERCENTAGE
1	0%	6	13%
2	0%	7	22%
3	5%	8	30%
4	8%	9	40%
5	9%	10 & Over	50%

TERMINATION

Coverage will terminate and no benefits will be payable under this rider on the earliest of the following:

- the date Your policy terminates for any reason;
- when any premium due for this rider is not paid before the end of the grace period;
- the date We receive Your written request at Our administrative office to terminate this rider unless Your request specifies a later date; or
- the policy anniversary following Your age [65].

Assurity Life Insurance Company has signed this rider on the Issue Date.



President

Secretary

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Administrative Office
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Assurity
Life Insurance Company

SUPPLEMENTAL DISABILITY INCOME RIDER

This rider is attached to and part of Your policy. The terms of Your policy apply to this rider unless otherwise stated in this rider. This rider is issued in return for Your approved application and the Initial Premium. Premium for this rider is included in the Initial Premium shown on the Policy Schedule. Rider premiums are paid to Our administrative office at the same time as policy premiums. We can change the premium rates. If We change the premium rates, We can only do it after approval or acknowledgement by Your state for all insured persons in Your class. You will be given 31 days notice by mail prior to any premium change.

RIDER SCHEDULE

Insured Person	[ ]
Issue Date	[ ]
Supplemental Disability Income Monthly Benefit	$[ ]
Maximum Supplemental Benefit Period	[ ]

DEFINITIONS

Maximum Supplemental Benefit Period means the maximum period of time, as shown on the Rider Schedule, the Supplemental Disability Income Monthly Benefit is payable if You are Totally Disabled. Supplemental Disability Income Monthly Benefits will not be paid past the policy anniversary following Your age [65].

Social Insurance Benefits means the following:

- ***Social Security Disability Benefit*** - any primary or family disability benefits You are eligible for under the U.S. Social Security Act or similar law of any other country. Payments under the retirement provisions of the Social Security Act are treated as a Social Security Disability Benefit.
- ***Worker's Compensation*** - any benefits You are eligible for under any Worker's Compensation Act or Occupational Disease Law. Included are all state and U.S. territory laws, as well as other countries' laws.
- ***Government Retirement and Disability Fund Benefit*** - any disability benefits You are eligible for (including dependent benefits) under any Federal, State, County, City or other governmental subdivision retirement and/or disability fund. Retirement benefits from such funds are treated as disability benefits.
- ***Railroad Retirement Disability Income*** - any primary or family disability benefits You are eligible for under the Railroad Retirement Act. Retirement option benefits under the Act are treated as disability benefits.

RIDER BENEFIT

We will pay the Supplemental Disability Income Monthly Benefit less any Social Insurance Benefits received if You are Totally Disabled and the Elimination Period has been satisfied. We will only pay benefits while you are Totally Disabled or to the end of the Maximum Supplemental Benefit Period, whichever is first. No benefits will be paid if Social Insurance Benefits exceed the Supplemental Disability Income Monthly Benefit amount.

If You receive a lump sum payment of Social Insurance Benefits, We will treat the lump sum as if it were paid over several months. The lump sum will be divided by the Supplemental Disability Income Monthly Benefit less the monthly Social Insurance Benefits. The result will be the number of months future rider benefits will not be paid. If the monthly Social Insurance Benefits exceeds the Supplemental Disability Income Monthly Benefit amount, we will not seek a refund of Supplemental Disability Income Monthly Benefits paid before the Social Insurance Benefit lump sum was received.

Supplemental Disability Income Monthly Benefits will be paid for only one of two or more Concurrent Disabilities. A Total Disability from the same Sickness or Injury is subject to one Maximum Supplemental Benefit Period. We will not pay for both Sickness and Injury for the same period of Total Disability.

RIDER CONDITIONS

Payment of the Supplemental Disability Income Monthly Benefit is subject to the following conditions:

- You apply for any Social Insurance Benefits for which You are eligible in a timely manner;
- You provide Us with written proof that You have applied for Social Insurance Benefits along with the amount that You qualify to receive;
- You provide Us with written permission to obtain information on Your application, reapplication or appeal for Social Insurance Benefits;
- You actively pursue all appeal procedures available in a timely manner if denied Social Insurance Benefits;
- You reapply for Social Insurance Benefits at Our request if there is a change in circumstances or in the law; and
- You provide Us with proof of any award or payment of Social Insurance Benefits as soon as they are received and notify Us of any change in benefit eligibility or payment status in a timely manner.

TERMINATION

Coverage will terminate and no benefits will be payable under this rider on the earliest of the following:

- the date Your policy terminates for any reason;
- when any premium due for this rider is not paid before the end of the grace period;
- the date We receive Your written request at Our administrative office to terminate this rider unless Your request specifies a later date;
- the policy anniversary following Your age [65];
- the date Social Insurance Benefits are repealed by law;
- the date You establish residence in a foreign country and become ineligible for Social Insurance Benefits; or
- the premium due date after:
  - You start receiving Social Security Retirement Benefits; or
  - You are eligible to receive unreduced Social Security Retirement Benefits.

Assurity Life Insurance Company has signed this rider on the Issue Date.

President

Secretary

Assurity Life Insurance Company
Administrative Office
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DISABILITY INCOME PRODUCT SECTION

Please complete for either Personal Disability Income or Business Overhead Expense Disability Income.

Survivor Benefit Beneficiary Name _____
First *Middle* *Last*

Relationship to Insured _____ Date of Birth *(MM/DD/YYYY)* ____/____/____

PERSONAL DISABILITY INCOME

Monthly Base Amount $ _____ Occupation Class: ☐ 4 A ☐ 3 A ☐ 2 A ☐ 1 A

Elimination Period: ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days ☐ 365 days

Benefit Period: ☐ 1 Year ☐ 2 Years ☐ 5 Years ☐ 10 Years ☐ To age 65 ☐ To age 67

ADDITIONAL BENEFITS *(If available)*
Check benefit(s) desired and indicate amount requested.

☐ Supplemental Disability Income Rider $ _____ ☐ Guaranteed Insurability Rider ☐ Residual Disability Benefit Rider

☐ Critical Illness Benefit Rider $ _____ ☐ Automatic Benefit Increase Rider ☐ Non-Cancelable Rider

☐ Other *(Specify)* _____ $ _____ ☐ Retroactive Injury Benefit Rider ☐ Return of Premium Benefit Rider

☐ 5-Year Own Occupation Rider *(not available with 1 or 2-Year Benefit Period)*

☐ 10-Year Own Occupation Rider *(available with 10-Year Benefit Period)*

☐ To Age 65 Own Occupation Rider *(available with To Age 65 Benefit Period)*

☐ To Age 67 Own Occupation Rider *(available with To Age 67 Benefit Period)*

☐ Catastrophic Disability Benefit Rider *(Select desired Benefit Period for Catastrophic Disability Benefit Rider.)*

Available with 1-Year Base Benefit Period: ☐ 4-Year Rider Benefit Period OR ☐ 9-Year Rider Benefit Period

Available with 2-Year Base Benefit Period: ☐ 3-Year Rider Benefit Period OR ☐ 8-Year Rider Benefit Period OR ☐ To Age 65 Benefit Period

Available with 5-Year Base Benefit Period: ☐ 5-Year Rider Benefit Period OR ☐ To Age 65 Benefit Period

Available with 10-Year Base Benefit Period: ☐ To Age 65 Benefit Period

BUSINESS OVERHEAD EXPENSE DISABILITY INCOME

Monthly Base Amount $ _____ Occupation Class: ☐ 4 A ☐ 3 A ☐ 2 A

Elimination Period: ☐ 30 days ☐ 60 days ☐ 90 days

Benefit Period: ☐ 1 Year ☐ 2 Years

Average monthly expenses currently incurred, for which the Proposed Insured is liable:

Type of Expense	Monthly Amount	Type of Expense	Monthly Amount
Employees' salaries	$	Accounting fees	$
Utilities *(electricity, gas, water, telephone)*	$	Property/payroll taxes	$
Business space *(rent/mortgage payment)*	$	Other eligible expenses *(Please list)*	
Furniture/equipment payments *(lease or principal)*	$		$
Laundry, office maintenance	$		$
Business insurance premiums	$		$
		Total Monthly Expenses	$

SERFF Tracking Number:	*SEFL-126544635*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*45354*
Company Tracking Number:	*PDI H0920*		
TOI:	*H11I Individual Health - Disability Income*	*Sub-TOI:*	*H11I.008 Combined Short Term and Long Term - Unrelated to marketing with employer or association groups*
Product Name:	*PDI H0920*		
Project Name/Number:	*PDI H0920/PDI H0920*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	04/30/2010

Comments:

Attachment:

READ CERT.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	04/30/2010

Comments:

Attachment:

ADIAR.pdf

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	04/30/2010

Bypass Reason: Outline of Coverage is submitted under the form schedule.

Comments:

		Item Status:	Status Date:
Satisfied - Item:	Statement of Variabiltiy	Approved-Closed	04/30/2010

Comments:

Attachment:

Statement_of_Variability.pdf

READABILITY CERTIFICATION

I hereby certify the following forms were tested for readability using Microsoft® Word XP program and achieved the following test results:

Company Name: Assurity Life Insurance Company

Form Number(s): **I H0920 et al.**

Type of Form: Disability Income

Form No.	Description	Flesch Score
I H0920 (AR)	Disability Income Insurance Policy	50.0
OC-I H0920 (AR)	Outline of Coverage	50.0
R I0921	Own Occupation Rider	50.3
R I0922	Automatic Benefit Increase Rider	59.5
R I0923	Catastrophic Disability Benefit Rider	51.2
R I0924	Guaranteed Insurability Rider	53.5
R I0925	Non-Cancelable Rider	51.3
R I0926	Residual Disability Benefit Rider	53.3
R I0927	Retroactive Injury Benefit Rider	56.2
R I0928	Return of Premium Benefit Rider	50.6
R I0929	Supplemental Disability Income Rider	51.9
47-360-05051 (R03-10)	Disability Income Product Section (scored with policy form I H0920)	50.1

Carol S Watson
Signature

April 5, 2010
Date

Carol S. Watson
Vice President, General Counsel and Secretary

ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(402) 476-6500 • (800) 276-7619 • FAX (402) 437-4591

Application for INSURANCE

PLEASE PRINT WITH BLACK INK

1. PROPOSED INSURED

Legal Name (First, Middle, Last)			Date of Birth (MM/DD/YYYY) / /
Social Security No.	☐ Male ☐ Female	E-mail	Age
Home Address (Street Address, City, State, ZIP+4)			
Personal Phone No. ( )	Birth State/Country	Height ft. in.	Weight lbs.

Has the Proposed Insured ever used any form of tobacco or nicotine-based products, or substitutes such as patches or gum? ..... ☐ Yes ☐ No

If YES, please list type and last date of use (MM/DD/YYYY) / /

Is the Proposed Insured a United States citizen, or does the Proposed Insured have permanent resident *(green card)* status? ..... ☐ Yes ☐ No

Does the Proposed Insured have a valid driver's license? ☐ Yes ☐ No If YES, please list state of issue and number

Is the Proposed Insured currently working at least 30 hours per week in primary occupation? ☐ Yes ☐ No Length of employment Years / Months /

Primary Employer	Employer's Address (Street Address, City, State, ZIP+4)				
Full-time Employment	Occupation	Duties	Part-time Employment	Occupation	Duties
Gross monthly income $			If self-employed, net monthly income $		

2. POLICYOWNER *(Policyowner is the Proposed Insured unless otherwise indicated)*

If Ownership is a trust, complete the Trust Information/Additional Beneficiary form rather than this section.

Legal Name (First, Middle, Last)			Date of Birth (MM/DD/YYYY) / /
Social Security No.	Relationship to Insured		Birth State/Country
Home Address (Street Address, City, State, ZIP+4)			E-mail Address
Contingent Owner's Name (First, Middle, Last)			Contingent Owner's Relationship to Insured

3. BENEFICIARIES *(Do not complete if applying for Reversionary Annuity or Disability Income coverage)*

If Beneficiary is a trust, complete the Trust Information/Additional Beneficiary form rather than this section.

Primary Beneficiary Name *(First, Middle, Last)*	Relationship	Soc. Sec. No.	Date of Birth	Share %
			/ /	
			/ /	
			/ /	
Contingent Beneficiary Name *(First, Middle, Last)*	**Relationship**	**Soc. Sec. No.**	**Date of Birth**	**Share %**
			/ /	
			/ /	
			/ /	

4. PREMIUM PAYMENT MODE

☐ Annual ☐ Semi-Annual ☐ Quarterly

☐ Monthly *(Automatic Bank Withdrawal)* ☐ Monthly *(Credit Card)* ☐ List Bill

Payor Name (First, Middle, Last)		Billing Address (Street Address, City, State, ZIP+4)	
Secondary Payor Info. (First, Middle, Last)		Billing Address (Street Address, City, State, ZIP+4)	

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Application for INSURANCE

PLEASE PRINT WITH BLACK INK

5. PROPOSED JOINT INSURED

Legal Name (*First Middle Last*)			Date of Birth (*MM/DD/YYYY*) / /
Social Security No.	☐ Male ☐ Female	E-Mail	Age
Home Address (*Street Address City State ZIP+4*)			
Personal Phone No. ( )	Birth State/Country	Height ft. in.	Weight lbs.

Has the Proposed Insured ever used any form of tobacco or nicotine-based products, or substitutes such as patches or gum? ..... ☐ Yes ☐ No

If YES, please list type and last date of use *(MM/DD/YYYY)* / /

Is the Proposed Insured a United States citizen, or does the Proposed Insured have permanent resident *(green card)* status? ..... ☐ Yes ☐ No

Does the Proposed Insured have a valid driver's license? ☐ Yes ☐ No If YES, please list state of issue and number

Is the Proposed Insured currently working at least 30 hours per week in primary occupation? ☐ Yes ☐ No Length of employment *Years* *Months* /

Primary Employer	Employer's Address (*Street Address City State ZIP+4*)		
Full-time Employment (*Occupation Duties*)		Part-time Employment (*Occupation Duties*)	
Gross monthly income $		If self-employed, net monthly income $	

TRUST INFORMATION/ADDITIONAL BENEFICIARY

Please complete the following sections if Ownership and/or Beneficiary is a trust *(or if additional room is needed to list beneficiaries of Policy)*:

1. POLICYOWNER *(Policyowner is the Proposed Insured unless otherwise indicated)*

First	*Middle*	*Last*	*(MM/DD/YYYY)*
Name			Date of Birth / /
Social Security No.			Relationship to Insured
Street Address	*City*	*State*	*ZIP+4*
Home Address			
Contingent Owner's Name			Contingent Owner's Relationship to Insured

2. BENEFICIARIES *(Do not complete if applying for Reversionary Annuity)*

Primary Beneficiary Name *(First, Middle, Last)*	Relationship	Social Security No.	Date of Birth *(MM/DD/YYYY)*	Share %
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	

Contingent Beneficiary Name *(First, Middle, Last)*	Relationship	Social Security No.	Date of Birth *(MM/DD/YYYY)*	Share %
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
☐ Testamentary Trust *(Will)*	N/A	N/A	N/A	
☐ Living Trust *(Please complete section below.)*	N/A	N/A	N/A	

Name of Living Trust _____

Date of Trust *(MM/DD/YYYY)* / / Tax ID No. of Trust _____

Name of Trustee(s) _____

Address of Trustee(s) _____

GENERAL SECTION

Please answer the following questions:

1. Does any Proposed Insured belong to or intend to join the National Guard or military? ☐ Yes ☐ No

   If YES, please explain: _____

2. During the past **5 years** or within the next **12 months** *(If YES to any of the following, please complete and return the Avocation Questionnaire)*:

   a. Has any Proposed Insured flown other than as a fare-paying passenger, or is any Proposed Insured contemplating flying as a pilot, crew member or student? ☐ Yes ☐ No

   b. Has any Proposed Insured participated in, or contemplated participation in, any hazardous sport or activities? ☐ Yes ☐ No

   If YES, check all that apply:
   ☐ Skin/Scuba Diving ☐ Bungee Jumping ☐ Skydiving/Parachuting/Hang Gliding
   ☐ Motor-powered Racing ☐ Boxing ☐ Rodeo ☐ Professional, Semi-professional or Club Sports
   ☐ Cave Exploration ☐ Mountain/Rock/Ice Climbing ☐ Hot Air Ballooning

3. During the next **12 months**, does any Proposed Insured contemplate residence or travel outside of the United States? ☐ Yes ☐ No

   If YES, please explain: _____

4. During the past **12 months**, has any Proposed Insured had a change in weight of more than 10 pounds? ☐ Yes ☐ No
   If YES, please list Proposed Insured's name, amount of weight change and reason for change:

   _____

5. During the past **5 years**, has any Proposed Insured:

   a. Had a life, health or hospital expense insurance application postponed, rated up, ridered or declined, or had insurance renewal or reinstatement refused? ☐ Yes ☐ No

   If YES, please explain: _____

   b. Received benefit payments for accident or sickness, or applied to any government or insurance organization for such benefits? ☐ Yes ☐ No

   If YES, please explain: _____

6. Is any Proposed Insured currently negotiating for other insurance coverage? ☐ Yes ☐ No

   If YES, please explain: _____

7. During the past **5 years**, has any Proposed Insured:

   a. Had their driver's license suspended or revoked, been convicted of or pleaded "guilty" or "no contest" to driving under the influence *(DUI/DWI)*, or had more than 3 moving violations? ☐ Yes ☐ No

   If YES, please explain: _____

   b. Been convicted of a felony? ☐ Yes ☐ No

   If YES, please explain: _____

8. Is any Proposed Insured currently on probation? ☐ Yes ☐ No
   If YES, please list Proposed Insured's name, reason for probation and length of probationary period:

   _____

9. If this insurance is issued, will it replace, modify or borrow against existing or pending coverage? ☐ Yes ☐ No
   If YES, please complete and return the appropriate State Replacement Form.

10. Does any Proposed Insured have other insurance coverage in force? If YES, please provide details below. ☐ Yes ☐ No

Company Name	Policy No.	Individual *(I)* Group *(G)*	Benefits *(monthly benefit and benefit period for DI or face amount for Life)*	Issue Date *(MM/DD/YYYY)*	DI Coverage Only: Coordinates w/ Soc. Sec.?	DI Coverage Only: Employer Paid?
		☐ I ☐ G		/ /	☐ Yes ☐ No	☐ Yes ☐ No
		☐ I ☐ G		/ /	☐ Yes ☐ No	☐ Yes ☐ No
		☐ I ☐ G		/ /	☐ Yes ☐ No	☐ Yes ☐ No

HEALTH SECTION

Please answer the following questions. If YES to any of the following, please provide details on page 2.

1. Has any Proposed Insured **ever** consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for any of the following:

   a. Heart disorder, including a heart attack *(myocardial infarction)*, angina, irregular heartbeat or abnormal heart rhythm *(arrhythmia)*, chest pain, hypertension *(high blood pressure)*, heart murmur, any blockage or narrowing of the arteries, any aneurysm, stroke or transient ischemic attack *(TIA or mini-stroke)*, or rheumatic fever? ☐ Yes ☐ No

   b. Diabetes, high blood sugar or sugar in the urine, anemia, blood or platelet disorders, elevated cholesterol, liver disease, hemophilia, kidney disease *(other than kidney stones)*, protein or blood in the urine, Crohn's disease, ulcerative colitis, disease or disorder of the stomach, gall bladder, bladder or prostate, other intestinal or digestive tract disease, or pancreatitis? ☐ Yes ☐ No

   c. Internal cancer or tumor, cyst, melanoma, lymphoma, leukemia, disorder of lymph nodes or any glandular disorder? ☐ Yes ☐ No

   d. Alzheimer's disease, dementia, memory loss, seizures, mental retardation *(including Down's syndrome)*, multiple sclerosis *(MS)*, muscular dystrophy *(MD)*, Parkinson's disease, amyotrophic lateral sclerosis *(ALS)*, any brain or nervous system disorder, cerebral palsy or any form of muscular atrophy? ☐ Yes ☐ No

   e. Sleep apnea, cystic fibrosis, emphysema or chronic obstructive pulmonary disease *(COPD)*, shortness of breath, asthma or other respiratory disorder, rheumatoid arthritis, paralysis or connective tissue disorder *(lupus or scleroderma)*? ☐ Yes ☐ No

   f. Dizziness, fainting spells, anxiety, depression, eating disorders or any other psychological or emotional disorder? ☐ Yes ☐ No

   g. Arthritis, rheumatism or any disease or disorder of the back, spine, bones, joints or muscles? ☐ Yes ☐ No

   h. Varicose veins, varicose ulcer or phlebitis, syphilis or a hernia? ☐ Yes ☐ No

   i. Any disease or disorder of the eyes, ears, nose or throat? ☐ Yes ☐ No

   j. Any other illness or injury requiring medical attention or blood transfusions? ☐ Yes ☐ No

2. During the past **5 years**, has any Proposed Insured:

   a. Been a patient in any hospital, clinic, dependency program, halfway house or other medical facility? ☐ Yes ☐ No

   b. Used controlled substances such as cocaine, heroin, amphetamines, barbiturates, hallucinogens or any other controlled substance not prescribed by a physician? ☐ Yes ☐ No

   c. Been treated by a physician, or advised by a physician to seek treatment, for drug or alcohol use? ☐ Yes ☐ No

   d. Been advised to have any test *(except HIV tests)*, treatment, surgery, hospitalization or consultation with a medical professional which has not been completed, or for which results have not been received? ☐ Yes ☐ No

   e. Had any special examinations or laboratory tests such as X-rays, electrocardiograms, blood tests *(other than AIDS-related blood tests)* or urine tests? ☐ Yes ☐ No

3. Has any Proposed Insured **ever** been diagnosed or treated by a medical professional for acquired immune deficiency syndrome *(AIDS)*, AIDS-related complex *(ARC)* or antibodies to human T-lymphotropic virus type III *(HTLV)*; or had a positive test for human immunodeficiency virus *(HIV)* antibodies? ☐ Yes ☐ No

4. Has any Proposed Insured had a natural parent or sibling who was diagnosed with or died of cancer, heart disease or diabetes prior to the age of 60? If YES, please identify family member, relationship to Proposed Insured, disorder and age at death. ☐ Yes ☐ No

   _____

5. a. Has any Proposed Insured **ever** had any disorder of any genital or reproductive organ, or had a miscarriage, stillbirth or Caesarean section? ☐ Yes ☐ No

   b. Is any Proposed Insured currently pregnant? ☐ Yes ☐ No

   If YES, date child is expected *(MM/DD/YYYY)* ____/____/____

DETAILS: Enter complete details from questions #1-5 on page 2. If more space is needed, attach additional Supplemental Information form.

SUPPLEMENTAL INFORMATION

Question #/Letter	Name *(First, Middle, Last)*	Onset Date *(MM/DD/YYYY)*	Duration *(Days, Mos, Yrs)*	Health Condition and Details	Medical Care Provider's Name/Address/Phone
		/ /			
		/ /			
		/ /			
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		/ /			
		/ /			

Additional Information:

Home Office Use Only

PRIMARY PHYSICIAN INFORMATION

Name _____
First *Middle* *Last*

Address _____
Street Address *Suite*

_____
City *State* *ZIP+4*

Phone No. ( ) _____ Fax No. ( ) _____

Date last consulted *(MM/DD/YYYY)* ____/____/____ Reason for consultation _____

Results _____

AGREEMENT

I *(We)* have read the above questions and answers and declare that they are complete and true to the best of my *(our)* knowledge and belief. I *(We)* agree that this application shall form a part of the policy if attached thereto.

I *(We)* agree that:

a. In the event the first full premium on the policy applied for is paid upon the date of this application, the insurance under such policy shall take effect as provided in the Conditional Receipt delivered by the Company's agent in exchange for such payment.

b. In the event the first full premium on the policy applied for is not paid upon the date of this application, the insurance under such policy shall not take effect unless: a) The application is approved by the Company at its home office, b) Such policy is issued and delivered to the Proposed Insured/ Owner, and c) Such first full premium is paid during the Proposed Insured's lifetime and continued good health and the life and continued good health of any other person(s) covered under the policy. When such approval, issue, delivery and payment have occurred, the insurance under such policy shall take effect as of the date of issue specified in the policy.

c. No agent or medical examiner is authorized or has power to change or waive any term, provision or condition of this application, the Conditional Receipt or the policy applied for, or to pass upon or approve insurability of any person for whom insurance is applied for.

Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a substantial civil penalty where and to the extent allowed by state law.

Substitute Form W-9 information *(Request for Taxpayer Identification Number and Certification)*: I, the Owner *(or each Joint Owner)*, certify under penalties of perjury that the number shown is my correct Taxpayer Identification Number. I am not subject to backup withholding due to failure to report interest and dividend income, and I am a U.S. Person *(including a U.S. resident alien)*. The Internal Revenue Service does not require my consent to any provision of this document other than the certification required to avoid backup withholding.

Signed at _____ on ____/____/____
City *State* *Date (MM/DD/YYYY)*

_____ _____
Signature of Proposed Insured *Signature of Additional Proposed Insured*

_____ _____
Signature of Additional Proposed Insured *Signature of Parent/Guardian of Minor Child*

_____ _____
Signature of Owner(s) (If other than Proposed Insured) *Signature of Beneficiary (If applying for Reversionary Annuity)*

_____ _____
Signature of Licensed Agent *Print Agent Name and Agent No.*

FIELD UNDERWRITER'S STATEMENT

Please answer the following questions:

1. a. What amount was collected with this application? $ _____

   b. Has a Conditional Receipt been given to the Policyowner? ☐ Yes ☐ No

   c. Has the Proposed Insured signed a Confidential Information Authorization and been given a Fair Credit and MIB Notification? ☐ Yes ☐ No

2. a. Did you personally see all Proposed Insured(s) on date of application? ☐ Yes ☐ No

   b. How well do you know the Proposed Insured(s)? ☐ Well ☐ Slightly ☐ Not at all

   c. Are you aware of anything about the health, habits, hobbies or mode of living which might affect the insurability of the Proposed Insured? If YES, please provide details below. ☐ Yes ☐ No

   _____

   d. Is the Proposed Insured(s) a citizen of the United States? If NO, provide a copy of a permanent visa—front and back. ☐ Yes ☐ No

3. Is this application being submitted on a non-medical basis? If NO, check items below for which arrangements have been made. ☐ Yes ☐ No

   ☐ Abbreviated paramedical examination *(Tele-app only.)*

   ☐ Paramedical examination with Home Office *(H.O.)* specimen. *(Preferred classifications require blood profile, not dried blood spot.)*

   ☐ Medical exam by physician with H.O. specimen ☐ Chest X-ray ☐ Blood Profile ☐ Electrocardiogram ☐ Treadmill

   Name and address of examiner _____

   Date above items to be completed *(MM/DD/YYYY)* ____/____/____

4. If this insurance is issued, will it replace, modify or borrow against existing or pending coverage? ☐ Yes ☐ No
   If YES, please complete and return the appropriate State Replacement Form.

5. Are commissions to be split? ☐ Yes ☐ No Agent No. _____ ____% Agent No. _____ ____%

AUTOMATIC PAYMENT OPTIONS

☐ Set up NEW bank withdrawal—signed authorization and voided check attached with the application.

☐ Add to existing bank withdrawal; indicate other applicant and/or policy numbers _____

☐ Set up NEW credit card payment—signed authorization attached with the application.

LIST BILL

☐ Set up NEW list bill.

☐ Add to existing list bill; indicate list bill no. _____ and/or name of company _____

FOR TERM LIFE APPLICATION

The premiums for this application were quoted on the following underwriting classification:

$350,000 and under: ☐ Select + NT ☐ Select NT ☐ Standard NT ☐ Select + T ☐ Select T ☐ Standard T

$350,001 and over: ☐ Preferred + NT ☐ Preferred NT ☐ Standard NT ☐ Preferred T ☐ Standard T

FOR WHOLE LIFE APPLICATION

All LifeScape® Whole Life cases require that either a signed illustration or a signed Illustration Disclosure Statement be submitted with the application.
The premiums for this application were quoted on the following underwriting classification:

☐ Preferred + ☐ Preferred ☐ Select NT ☐ Tobacco

FOR UNIVERSAL LIFE APPLICATION

The premiums for this application were quoted on the following underwriting classification:

☐ Preferred + ☐ Preferred ☐ Select NT ☐ Preferred T ☐ Standard T

FOR REVERSIONARY ANNUITY APPLICATION

All cases require that either a signed illustration or a signed Illustration Disclosure Statement be submitted with the application.
The premiums for this application were quoted on the following underwriting classification: ☐ Preferred NT ☐ Standard NT ☐ Tobacco

I hereby certify that to the best of my knowledge and belief, the answers on the application and in this statement are true and correct.

_____	____/____/____	(____) ____/(____)
Signature of Soliciting Agent	*Date (MM/DD/YYYY)*	*Business Phone No. and Fax No.*
_____	_____	_____
Soliciting Agent's Printed Name	*Agent No.*	*Agent's E-mail*

Explanation of Variables

Variable data is shown in brackets [xxxx]

Form I H0920, Disability Income Policy

Page 1

1. **Guaranteed Renewable Age –** The age that the policy is guaranteed renewable to. It will print 65 unless the benefit period chosen is To Age 67. Then and only then will it print 67

2. **Representative Name –** This is variable to allow for specific agent information.

3. **Address –** This is variable to allow for specific agent information.

4. **Telephone –** This is variable to allow for specific agent information.

Page 3

5. **Initial Annual Premium –** The premium for the policy contract and any riders.

6. **Total Disability Monthly Benefit –** The amount we agree to pay if the insured is totally disabled. The range is $200 to $9,000.

7. **Maximum Benefit Period –** The maximum period of time the monthly benefit is payable. The options are 1 year, 2 years, 5 years, 10 years, to age 65 and to age 67.

8. **Elimination Period –** The number of consecutive days the insured must be totally disabled before they are eligible to receive benefits. The options are 30, 60, 90, 180 and 365 days.

9. **Partial Disability Monthly Benefit –** The amount we agree to pay if the insured is partially disabled. It is equal to ½ of the total disability monthly benefit.

10. **Own Occupation Rider –** Changes the definition of total disability as it relates to the insured being able to do their own occupation. The options are 5 year, 10 year, to age 65 and to age 67.

11. **Catastrophic Disability Monthly Benefit –** The amount We agree to pay the insured is catastrophically disabled. The monthly benefit is the same as the policy's total disability monthly benefit.

12. **Maximum Catastrophic Benefit Period –** The maximum period of time the catastrophic disability monthly benefit is payable due to a catastrophic disability. The options (depending on the policy benefit period) are 3, 4, 5, 8, 10 years or to age 65.

13. **Maximum Increase Amount –** The maximum amount by which the total disability monthly benefit can be increased. The range is $200 - $600.

14. **Maximum Residual Benefit Period –** The maximum period of time the residual disability monthly benefit is payable due to residual disability. The options are 1 year, 2 years or 5 years.

15. **Supplemental Disability Income Monthly Benefit –** The amount we agree to pay, less any Social Insurance Benefits received, if the insured is totally disabled and the elimination period has been satisfied. The range is $100 - $1,800, subject to changes in Social Security Insurance maximums.

16. **Maximum Supplemental Benefit Period –** The maximum period of time the supplemental disability income monthly benefit is payable. The benefit period is the same as the base policy benefit period.

17. **Critical Illness Benefit Rider-Benefit Amount –** It provides a lump sum payment if the insured is diagnosed with one of the specified critical illnesses defined in the rider. The benefit amount range is $5,000 to the lesser of 36 times the total disability monthly benefit or $150,000.

18. **Insured Person –** The name of the person insured by the policy.

19. **Policy Number –** A unique number assigned to a policy at issue and used for identification.

20. **Age –** The insurance age of the insured at time of issue. The range is 18-60 (age nearest birthday).

21. **Issue Date –** The issue date of the policy.

22. **Gender –** The gender of the insured. The options are male or female.

23. **Initial Premium –** The premium submitted in exchange for the policy contract and any riders.

24. **Class –** The underwriting classification of non-tobacco or tobacco.

25. **Premium Period –** The frequency at which policy renewal premiums are payable. The options are 12 months, 6 months, 3 months or 1 month.

26. **Premium Modes –** Indicates what the premium is for each premium mode available based on the policy issued.

Page 4

27. **Maximum Benefit Period –** States when benefits will not be paid past. The first and third set of brackets will be 65 or 67. The second set of brackets will be 63 or 65, respectively.

Page 9

28. **Termination, 4th bullet** – States when the guaranteed renewability stops. Both brackets will state either 65 or 67.

Page 11

29. **Guaranteed Renewable Age –** The age that the policy is guaranteed renewable to. It will print 65 unless the benefit period chosen is To Age 67. Then and only then will it print 67

Form OC-I H0920, Outline of Coverage

Page 3

1. **Renewability –** The age that the policy is guaranteed renewable to. It will print 65 unless the benefit period chosen is To Age 67. Then and only then will it print 67

2. **Optional Benefit Riders: Own Occupation Rider –** This rider changes the definition of total disability as it relates to the insured being able to do their own occupation. The options for the rider title are 5 year, 10 year, to age 65 and to age 67. The text within the rider depends on the time frame. If it is a 5 year own occupation, the rider will read as follows:

   "Total Disability; Totally Disabled means a disability due to Sickness or Injury which:

   - starts while this policy is in force;
   - requires a Physician's care unless Your Physician certifies You have reached the maximum point of recovery;
   - for the first five years after the Elimination Period, keeps You from doing all the substantial and material duties of Your Own Occupation; and
   - after benefits have been paid for five years, keeps You from doing all the substantial and material duties of Any Gainful Occupation.

   If You are able to perform one of more of the substantial and material duties of Your Own Occupation during the first five years after the Elimination Period, or of Any Gainful Occupation after benefits have been paid for five years, then you are not Totally Disabled."

   If it is any other own occupation, the rider will read as follows:

   "Total Disability; Totally Disabled means a disability due to Sickness or Injury which:

   - starts while this policy is in force;
   - requires a Physician's care unless Your Physician certifies You have reached the maximum point of recovery; and
   - after the Elimination Period, keeps You from doing all the substantial and material duties of Your Own Occupation.

   If You are able to perform one of more of the substantial and material duties of Your Own Occupation after the Elimination Period, then you are not Totally Disabled."

Form R I0921, Own Occupation Rider

1. **Optional Benefit Riders: Own Occupation Rider –** This rider changes the definition of total disability as it relates to the insured being able to do their own occupation. The options for the rider title are 5 year, 10 year, to age 65 and to age 67. The text within the rider depends on the time frame. If it is a 5 year own occupation, the rider will read as follows:

"Total Disability; Totally Disabled means a disability due to Sickness or Injury which:

- starts while this policy is in force;
- requires a Physician's care unless Your Physician certifies You have reached the maximum point of recovery;
- for the first five years after the Elimination Period, keeps You from doing all the substantial and material duties of Your Own Occupation; and
- after benefits have been paid for five years, keeps You from doing all the substantial and material duties of Any Gainful Occupation.

If You are able to perform one of more of the substantial and material duties of Your Own Occupation during the first five years after the Elimination Period, or of Any Gainful Occupation after benefits have been paid for five years, then you are not Totally Disabled."

If it is any other own occupation, the rider will read as follows:

"Total Disability; Totally Disabled means a disability due to Sickness or Injury which:

- starts while this policy is in force;
- requires a Physician's care unless Your Physician certifies You have reached the maximum point of recovery; and
- after the Elimination Period, keeps You from doing all the substantial and material duties of Your Own Occupation.

If You are able to perform one of more of the substantial and material duties of Your Own Occupation after the Elimination Period, then you are not Totally Disabled."

2. **Termination, 4th bullet** – States when the guaranteed renewability stops. The options are the same as the policy.

Form R I0922, Automatic Benefit Increase Rider

1. **Insured Person –** The name of the person insured by the policy.

2. **Issue Date –** The issue date of the policy.

3. **Termination, 4th bullet** – States when the guaranteed renewability stops. The options are the same as the policy.

Form R I0923, Catastrophic Disability Benefit Rider

1. **Insured Person –** The name of the person insured by the policy.

2. **Issue Date –** The issue date of the policy.

3. **Catastrophic Disability Monthly Benefit –** The amount We agree to pay the insured is catastrophically disabled. The monthly benefit is the same as the policy's total disability monthly benefit.

4. **Maximum Catastrophic Benefit Period –** The maximum period of time the catastrophic disability monthly benefit is payable due to a catastrophic disability. The options (depending on the policy benefit period) are 3, 4, 5, 8, 10 years or to age 65.

5. **Termination, 4th bullet** – States when the guaranteed renewability stops. The options are the same as the policy.

Form R I0924, Guaranteed Insurability Rider

1. **Insured Person –** The name of the person insured by the policy.

2. **Issue Date –** The issue date of the policy.

3. **Maximum Increase Amount –** The maximum amount by which the total disability monthly benefit can be increased. The range is $200 - $600.

Form R I0925, Non-Cancelable Rider

1. **Insured Person –** The name of the person insured by the policy.

2. **Issue Date –** The issue date of the policy.

3. **Termination, 4th bullet** – States when the guaranteed renewability stops. The options are the same as the policy.

Form R I0926, Residual Disability Benefit Rider

1. **Insured Person –** The name of the person insured by the policy.

2. **Issue Date –** The issue date of the policy.

3. **Maximum Residual Benefit Period –** The maximum period of time the residual disability monthly benefit is payable due to residual disability. The options are 1 year, 2 years or 5 years.

4. **Elimination Period –** The number of consecutive days the insured must be totally or residually disabled before they are eligible to receive benefits. The options are 30, 60, 90, 180 and 365 days.

5. **Termination, 4th bullet** – States when the guaranteed renewability stops. The options are the same as the policy.

Form R I0927, Retroactive Injury Benefit Rider

1. **Insured Person –** The name of the person insured by the policy.

2. **Issue Date –** The issue date of the policy.

3. **Termination, 4th bullet** – States when the guaranteed renewability stops. The options are the same as the policy.

Form R I0928, Return of Premium Benefit Rider

1. **Insured Person –** The name of the person insured by the policy.

2. **Issue Date –** The issue date of the policy.

3. **Rider Benefit, 4th bullet** – States when we will pay the ROP benefit. The options are the same as the renewability of the policy and will be 65 or 67.

4. **Termination, 4th bullet** – States when the guaranteed renewability stops. The options are the same as the policy.

Form R I0929, Supplemental Disability Income Rider

1. **Insured Person –** The name of the person insured by the policy.

2. **Issue Date –** The issue date of the policy.

3. **Supplemental Disability Income Monthly Benefit –** The amount we agree to pay, less any Social Insurance Benefits received, if the insured is totally disabled and the elimination period has been satisfied. The range is $100 - $1,800, subject to change in the future based on Social Security Insurance maximums.

4. **Maximum Supplemental Benefit Period –** The maximum period of time the supplemental disability income monthly benefit is payable. The benefit period is the same as the base policy benefit period.

5. **Definitions, Maximum Supplemental Benefit Period** – States when we will stop paying the benefit. The options are the same as the renewability of the policy.

6. **Termination, 4th bullet** – States when the guaranteed renewability stops. The options are the same as the policy.